

A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF NURSES DIRECTLY
INVOLVED WITH TERMINATION OF PREGNANCIES IN THE LIMPOPO PROVINCE

by

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DECLARATION

I declare that A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF NURSES DIRECTLY INVOLVED WITH TERMINATION OF PREGNANCY IN THE LIMPOPO PROVINCE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signature: _____

Date: _____

I would like to thank the National Research Foundation (NRF) for the financial contributions and support to conduct this study

DEDICATION

This study is dedicated to my children, Katlego and Palesa; my parents, Mongalo and Phillemon; my brothers and sisters, Doris, Simon, Victor and Kedibone

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ABSTRACT

The South African government promulgated the Choice on Termination of pregnancy Act (CTOP Act, 92 of 1996). This was a dramatic declaration of intent unprecedented in the African continent and globally. This act changed the outlook of the practice of termination of pregnancy by ensuring that services play a critical role in the delivery of the service. This study, which is qualitative in nature, explored the experiences of Termination of Pregnancy service providers working in three designated public health institutions in the Limpopo Province. Interviews were conducted with six service providers to look at how they construct their practice of providing termination of pregnancy services. The information was analyzed and interpreted by means of a thematic analysis method. Major themes that emerged from the participants' experiences centred on their relationship with family, colleagues, management, clients, and the community reflecting a sense of alienation and lack of adequate infrastructural support. Inadequate support has been found to greatly contribute to the loss of interest in the work around abortion.

Key words: Termination of pregnancy, registered midwife, social constructionism; social support, phenomenological research, CTOP Act (no 92, 1996), women's reproductive rights, South African context.

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CHAPTER 1

ORIENTATION

1.1 Introduction

It has been just over a decade since the legalization and implementation of the Choice on Termination of Pregnancy Act no. 92 of 1996 (Government Gazette, 1996). Before then, termination of pregnancy was considered a criminal act in South Africa and was regulated through restrictive and inaccessible provisions of the Abortion and Sterilization Act no. 2 of 1975 (Government Gazette, 1975).

The CTOP Act (Government Gazette, 1996) characterizes the South African government's revolutionary efforts to respond positively to women's reproductive health concerns by promoting reproductive rights and the freedom to choose to have an early and safe termination of pregnancy. One of the ways in which the CTOP Act (Government Gazette, 1996) advances the mandate to improve the quality of life of women seeking abortion is by tasking the registered midwife with the responsibility of providing termination of pregnancy (TOP) services within the first trimester of pregnancy. This research explores the experiences of nurse midwives who provide termination of pregnancy services by focusing particularly on those who are working within the ambit of public health institutions in Limpopo Province. The basic reasons for such a focus are highlighted in the subsequent sections.

According to the stipulations of the CTOP ACT (Government Gazette, 1996), a TOP service provider is a registered midwife who has undergone the Midwifery Abortion Care Training Programme which was introduced during the process of passing the Act. Henceforth, TOP service provider will be used within the context of this study to refer to this group of nurses. It is important to distinguish between a TOP service provider and a registered nurse. The former refers to a trained midwife who has specialized skills in managing and executing terminations of pregnancy which involves performing a manual vacuum aspiration procedure. The latter, on the other hand, is a nurse who has completed a general nursing diploma and is registered as such under the Nursing Act no. 50 of 1978 (Government Gazette, 1978).

The rest of the chapter comprises six sections. The first section provides the background of the study. The rationale is contained in the second section of the chapter. The aims and objectives as well as the problem statement are also discussed. The research method is briefly discussed in the fifth section and the chapter concludes with a brief presentation of the chapters contained in the rest of the thesis.

1.2 Background to the study

Limpopo is the northernmost province of South Africa, having international borders with Botswana, Zimbabwe and Mozambique. This province features quite prominently in the poverty rankings as being one of the least developed of the South African provinces (Gyekye & Akinboade, 2003; Pauw, 2005). Reports that have been issued out by

Statistics South Africa in 2000 confirm that Limpopo trots alongside the Eastern Cape for being the poorest in the country.

As money is needed to access a variety of services, poverty is often related to poor health, reduced access to facilities that provide health services, and physical environments that compromise personal safety. Poverty, therefore, tends to compromise the right to proper healthcare services of those who are affected. Women and children, both globally and regionally, tend to make up the majority of those who experience utter poverty or show high vulnerability of being poor. Poverty is therefore an important social issue not only because of its contribution to social exclusion but also because of its link to poorer health and the incidence of child and maternal deaths. The World Health Organization (WHO) estimates that 50 percent of the maternal mortality (which is currently estimated to be 529,000) is accounted for by abortion related deaths, which is also a significant contributor of maternal morbidity.

In recognizing the link between poverty and the realization of basic human rights, the CTOP Act (Government Gazette, 1996), which is commensurate with international law, for example, the Universal Declaration of Human Rights and the South African Bill of Rights in the constitution, acknowledges that women have the right to self-determination as well as the right to social assistance when they do not have the means to procure an abortion. Free abortion services provided through state facilities become a fundamental vehicle for ensuring that poverty ceases to be a determining factor for women's reproductive health risks and morbidity.

Ellen, Mwaba, Makoala and Trueman's (2004) facility assessment study in the Limpopo Province shows that, as of February 2003, there were only 26 TOP facilities which were fully functional with 5 facilities offering TOP on an intermittent basis. These facilities manage the reproductive needs of almost 1.5 million women of reproductive age in the province. Currently, there are 37 hospitals which have been designated to provide TOP services. Only 30 of them are currently offering the service. Obstacles in establishing the TOP service in other health facilities involve issues of conscientious objection. The conscientious objection clause in the 1996 CTOP Act allows health care workers to refuse to perform an abortion based on their personal beliefs and practices.

There are also 25 Community Health Centres (CHC) within the province which, according to the CTOP Amendment Act of 2004, are automatically designated as they offer a 24-hour maternity service. However, of these 25, only 5 are currently offering the service. Inadequate space and lack of proper equipment in other designated CHC's are offered as general explanations for the relatively small number of facilities meeting the requirements of the legislation. There are, therefore, a total of 35 TOP sites in the province which are characterized by 30 tertiary institutions in the form of hospitals and 5 CHC's (Department of Health, Limpopo Province, 2008). This report indicates that there has been an increase in the number of TOP sites and, therefore by implication, an improvement in the accessibility of TOP services.

The increase in the number of TOP sites and the number of clients requesting abortion means that there has to be an adequate number of trained TOP service providers. Currently, there are 190 trained TOP service providers in the province (DoH, Limpopo Province, 2008). Nationally, there are 975 TOP service providers that have been trained since 1996 (Department of Health, Republic of South Africa, 2008). The national figures are, however, not a true reflection of the termination of pregnancy human resources presently servicing designated health institutions nationally. Issues such as mobility of trained nurse midwives either to various working areas within the South African health sector or through migration to other countries continue to affect the number of service providers that remain working in public health institutions. Even though data about how many of the trained TOP providers are directly and continuously involved in offering the service could not be obtained, it became apparent during this study that not every service provider who has been trained, at least in the Limpopo Province, is directly involved on a continuous basis. Reports from the current study suggest that due to lack of space and inadequate technical equipment that are tailor-made for termination of pregnancy, in most instances, only one service provider is able to attend to clients at any given time.

1.3 Rationale for the study

One of the benefits of the legalization of abortion in South Africa has been the generation of improved access to TOP services particularly for women who do not have the financial means to procure an abortion privately. The service is made more accessible to the majority of women by ensuring that it can be rendered at the lowest level of health care.

This has inadvertently affected the number of abortion requests, thus impacting on the work load that TOP service providers have to manage.

According to Mckee and Adams (2004), most pregnancy terminations have been conducted within the first trimester of pregnancy. When judged alongside the stipulations of the legal provisions of the CTOP Act (Government Gazette, 1996), most abortions are provided by trained registered nurse midwives. Although a number of studies on termination of pregnancy have been conducted in rural areas of South Africa, they tend to root their focus exclusively on experiences within the Eastern Cape and KwaZulu Natal regions (Harrison, Montgomery, Lurie & Wilkinson, 2000; Mdleleni-Bookholane, 2007; Cele, 2000). This study therefore aims to contribute to some of the efforts of research that explore the circumstances within rural communities and the consequences of termination of pregnancy for women living within these contexts. Rural communities were primarily disadvantaged by the previous abortion laws as only a marginal part of the population was able to access abortion services (Engelbrecht, Pelser, Ngwena & van Rensburg, 2000; Mdleleni-Bookholane, 2007).

Many of the studies that have been conducted on termination of pregnancy tend to focus more on the psychosocial issues affecting the woman who contemplates an abortion and the psychological factors that are associated with the decision to undergo an abortion procedure and how women are affected post-abortion (Faure & Loxton, 2003; Suffla, 1997; Mdleleni-Bookholane, 2007; Cele, 2000). Little research has focused on the impact

and psychological consequences of termination of pregnancy for those who choose to provide the service.

The study is furthermore concerned with nurse midwives working in public health institutions in Limpopo. This group of providers is confronted with unique challenges as people that stand at the frontline of delivering on the mandate to provide services that are free and accessible and are often forced to manage increasing workload with minimal and sometimes inadequate resources.

A perusal of literature on termination of pregnancy indicates that very little has been written from a social constructionist perspective. It is believed that a social constructionist lens could make a valuable contribution to the literature on TOP.

1.4 Aims and objectives of the study

The objective of this study is to explore and describe the lived experiences of nurse midwives providing termination of pregnancy services in public health facilities in Limpopo Province. Identifying the lived experiences of TOP service providers will go a long way in enhancing our understanding of how they come to construct TOP and the provision of the service. Therefore, this study aims to provide a descriptive characterization of how nurse midwives make meaning out of their lived experiences of providing termination of pregnancy services.

1.5 Methodological and epistemological considerations

The study is qualitative and descriptive in nature. The theoretical perspective of social constructionism is pursued alongside the conceptual commitments of interpretive phenomenological analysis to understand how the life-world of nurse midwives providing termination of pregnancy services is socially and historically contingent and contextually bound.

Individual interviews were conducted with service providers who volunteered to be trained and to work as TOP nurses. Service providers were conveniently sampled (Terre Blanche & Durrheim, 1999) in health institutions in Limpopo Province and their written consent was obtained before the interviews could be conducted.

1.6 Problem statement

With an increase in abortion requests, there is a need for service providers who will be able to handle such stressful situations effectively. TOP service providers have been found to experience emotional disturbances related to the abortion work despite them having volunteered to provide the service (Ndhlovu, 1999). For TOP service providers to be able to deal with this emotionally demanding situation there is need to have their emotional/psychological well-being attended to by the different stakeholders. However, this cannot happen without firstly becoming aware of and understanding their daily experiences. There is therefore a need to identify how the provision of termination of pregnancy services is experienced and the challenges that inform this experience. Against this background the research questions informing this research are: 'What are the

experiences that inform nurse midwives volunteering to work as termination of pregnancy service providers?’ and ‘How do they create meaning for themselves out of providing Top services?’

1.7 Chapter overview

Chapter 1 has provided an orientation to the study. Background to the study was discussed. Furthermore, the problem statement, the objective and aims of the study and the motivation for the study were outlined.

In **Chapter 2**, termination of pregnancy is contextualized within the South African context. The rationale for this is discussed. The reflections of literature focusing on the experiences of service providers is reflected upon and elucidated.

Chapter 3 covers the theoretical framework that grounds the study. Social constructionism is used to explore how experiences which are essentially personal constructions are created and shaped through social interactions. This theoretical framework is further used to explore how service providers create and share these socially constructed realities about abortion.

Chapter 4 discusses the research method employed in this study. The rationale for selecting an interpretive, qualitative approach is discussed. The principles of an interpretive qualitative paradigm are discussed to ground the proposed analytical framework. This is followed by a discussion of the phenomenological method of

research. Ethics are furthermore considered in this chapter. The research process which details how data were collected and analyzed as well as how participants are selected is also considered in this chapter.

Results are presented in **Chapter 5** describing the various patterns and themes which have been lifted out of interviews.

In **Chapter 6**, results are discussed and contextualized within social constructionism. This is followed by a discussion of how themes that emerged from interviews are constructed. Recommendations for future possible studies are also provided in this chapter.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

Abortion has for centuries been a controversial issue that affects women around the world irrespective of race, socioeconomic status, educational level or religious background. There is often a veil of secrecy that shroud abortion, which tends to negatively influence the likelihood of a woman disclosing if she is contemplating or has had an abortion performed. Those that help women perform the abortion are also less likely to openly make their involvement in the practice known.

In most parts of the world, abortion is oftentimes opposed by government states, institutions, and individuals often leading to regulations which are not only strict but are also contradictory and complex. The majority of African countries, for example, regard abortion as a punishable offence and women face imprisonment for the offence. Any person who unlawfully assists a woman to have an abortion also risks receiving a prison sentence for the offence (Widdows, Idiakez & Cirion, 2006). Despite the evidence that such harsh legal provisions still constitute some of the realities that women have to grapple with, there is worldwide evidence of widespread changes in abortion laws which are not by far static. These laws give some reflection of how societies struggle to define what constitutes appropriate conduct for a woman's sexual and reproductive life while at

the same time stipulating what represents proper relationship between the state and the private lives of the people.

In this chapter, the trends in abortion law reforms are briefly traced, exploring more in detail the historical, legal and cultural aspects informing the South African context. The role of and the challenges facing termination of pregnancy service providers are also considered.

2.2. A historical review of abortion

2.2.1 The construction of abortion as a medical issue

Abortion involves some measure of moral and ethical uncertainties, which challenge legislators all over the world to resolve the social and legal discord as well as related medical confusion resulting from these uncertainties. Dixon-Mueller's (1990) international review of the legal provisions of abortion suggests that 76% of the world's population live in countries where induced abortion is legal only if performed according to very strict provisions while 39% of women reside in countries where abortion is available upon request. Abortion on request is in most cases restricted to the first trimester of pregnancy. Some of the provisions that are restrictive recognize abortion when it involves alleviating some form of threat to the physical or mental health of the pregnant woman. The threat must exceed the risk normally associated with pregnancy. Some criteria include instances where there is expected severe physical or mental impairment of the infant. Thus broad medical grounds tend to provide the basis around which understandings of abortion are formulated and how such constructions are kept

visible through various legal instruments. Some countries extend these exceptions in their legal provisions to include instances where the pregnancy resulted from rape or incest (juridical grounds), or when the effect of childbirth causes significant social problems to the woman or her family (Dixon-Mueller, 1990).

Abortion legal instruments in the South African context were historically formulated around the Roman Dutch law defense of therapeutic abortion. However, in 1975, the promulgation of the Abortion and Sterilization Act no. 2 of 1975 (Government Gazette, 1975) extended the grounds for performing abortions beyond the boundaries of therapeutic defense to include mental health exceptions, which required the approval of the state psychiatrist (Haroz, 1997; Ngwena, 1998).

As a medical issue, abortion impacted on the delivery of health care in South Africa. Illegal abortions accounted for approximately 33,000 surgical procedures done on women in hospitals per annum, and of these, 400 died. Guttmacher, Sally, Kapadia & de Pinho (1998) estimate that women presenting with complications of an illegal abortion constituted approximately 50 percent of patients admitted in Gynaecological wards. Treating these complications created a financial burden on the health system because the consequences of an illegal abortion are usually a longer stay in hospital, surgical interventions, anaesthesia, blood transfusions, and medications. In general, the health care system in South Africa was already grappling with the problem of shortage of doctors in public hospitals and inadequate facilities and resources to deal with natural conditions. The shortage of medical personnel is related to the migration of these

professionals to other state countries. Abortion patients therefore further crippled the system (Engelbrecht et al., 2000).

The cost of treating women with incomplete abortions in 1994 was estimated at 18.7 million rand. Consideration should be taken that this figure is an underestimation of the actual cost since only 10-50 percent of women with incomplete abortion present for treatment (Engelbrecht et al., 2000). In addition to illegal abortions having financial implications on the health care system, illegal abortion was often cited as the primary or secondary cause of maternal death (Hord & Xaba, 2001).

2.2.2. Socio-economic influences

Poverty is an important social issue for very many reasons, not least because of its contribution to social exclusion, and its link to poorer health and the incidence of maternal mortality. Maternal mortality and morbidity is a condition of abortion which is itself a condition of poverty and inequality in the sense that in most cases women and children tend to make up the majority both globally and regionally of those who experience utter poverty or show high vulnerability of being poor. The World Health Organization estimates that in developing countries 67 500 women die from abortion complications each year while in developed countries 300 die each year (Okonofua, 2006). In a country such as Ethiopia, abortion related deaths account for up to 50% of maternal mortality and are a significant cause of maternal morbidity. Poverty and inequality thus seem to play a significant role in influencing maternal mortality and morbidity. Ensuring that abortions are affordable, accessible and safe remains a daunting priority for governments and policy makers. Researchers such as Claire (1995) and Basu

(2003) also indicate increasing mortality rate as a result of abortion particularly in countries where it is a criminal offence to undergo or perform an abortion.

The laws which restrict access to legal abortions are indicated to be found mostly in developing countries, with a significant number in Sub-Saharan Africa, Latin America and the more fundamentalist Islamic nations. In traditional African countries such as Uganda and Kenya, sexuality and reproductive issues are understood and exercised within a socio-cultural context that is generally characterized by lack of gender equality which affects the ability of women to use contraception and other reproductive health services. This increases the risk of unwanted pregnancy and sexually transmitted infections (Packer, 2002; van der Westhuizen, 2005; Rosen & Conly, 1998). Bureaucratic regulations in countries like Zambia and India, amongst others, require the written permission of a husband or guardian, implying that a woman cannot make decisions independently. A woman may also be required to obtain authorization from two or three doctors, which in countries where there is a shortage of doctors, this requirement is almost always impossible to meet for the majority of women (Dixon-Mueller, 1990).

A woman's ability to access abortion services seems to depend on her economic status. Sarkin (1995) notes that while Austrian women have access to safe and legal abortion services, this is only in theory because in practice, the cost of having an abortion restricts access to these services. Irish women, who can afford financially, travel to the UK to terminate pregnancy. Women who are poor or lack resources to travel to the UK are left

with no option but to continue with unwanted pregnancy (Githens & Stetson, 1996; Claire, 1995; Sarkin, 1995; Widdows, Idiakez & Cirion, 2006).

South Africa hit its stride when termination of pregnancy was made a free health service in public health institutions in 1996. Haroz (1997) states that many women in South Africa, unable to access legal abortions mainly because of the restrictions of the abortion laws and because they were poor and thus could not afford to pay a private doctor, attempted to perform their own abortions using herbal enemas, knitting needles, oral quinine, castor oil or laxatives. Women also injected chemicals such as chloroxylenol or soapy solutions into their uteruses via catheters in order to induce an abortion. Other women faced with the same predicament resorted to less-skilled midwives or lay people (Guttmacher et al., 1998; Haroz, 1997).

South Africa is not the only country faced with the problem of illegal abortions. Studies indicate that in most countries where abortion is illegal, the law does not stop women from abortions, yet ensures that they can do so only under dangerous conditions (Basu, 2003). Strict regulations therefore do not stop abortions from being performed, but only ensures that they can happen under conditions that are dangerous and unsafe.

2.2.3 The influences of religion and culture

Religious thought and practice frequently provide valuable insights and information regarding how people's lives should be conducted. For one thing, the strength of religious convictions has the potential to deepen nonconformity to the ethics and mores of the

surrounding culture. Especially noteworthy in this respect is the opposition of religious and moral teachings of the church and African cultural proscriptions to contemporary practices of abortion.

The influence of the Catholic Church has been uniform in pronouncing opposition against abortion resulting in the most restrictive legislation in European countries like Ireland, for example (Widdows, Idiakez & Cirion, 2006). There is a legacy of the Christian and Islamic religious beliefs which also have a central hold in some African countries that upholds the sanctity of life that the church has preserved which continues to shape moral and ethical perceptions around abortion. Three important themes can be identified in religious and moral teachings regarding abortion: the foetus is the creation of God, the understanding of abortion as the culpable murder of a human being, and judgment falls on those guilty of abortion (Gorman, 1982). These themes indicate that abortion, when viewed from a religious point of view, is given a status which presents it as an offence against humanity. Furthermore, it is depicted as a dishonourable act or practice.

The longstanding religious principle of the sanctity of life reflects one significant position in the discourse on abortion referred to as pro-life. The pro-life stance holds a more conservative view which defends the foetus' right to life and the prohibitions on the taking of life (Haffajee, 1997).

According to Ngwena (1998), pre-colonial African communities are believed to have practiced abortion which was performed in line with customary beliefs and practices.

Even though it was not legally regulated, different ethnic groups are documented to have adopted different practices. The Southern Sotho people, for example, viewed abortion as a private rather than public matter. Issues around abortion were discussed within family structures rather than the indigenous court. In terms of the Tswana customary beliefs, abortion was a punishable offence and was probably not permitted under any circumstances. In the 20th century an Afrikaner home remedy book contained a folk recipe for abortion. Herbs and chemists' preparations were also widely used by Afrikaner women (SAMJ, 1997) (cited in Engelbrecht et al., 2000).

Ngwena's (1998) assertion that the practice of abortion was endorsed according to customary beliefs in some pre-colonial African communities highlights the role that social censure played to protect the institution of the family. His findings, coupled with the influence of religious moral teachings as discussed above, leads us to raise questions regarding whether abortion is an issue for which all of society is responsible and who has the power to veto the decision. Such demanding questions have informed and shaped debates on abortion for millennia, leading to contrasting views regarding whether abortion is ever acceptable and under what circumstances.

2.3. Human rights and Women's reproductive rights

According to Pillai & Wang (1999), the 19th century marked growing international concern for human rights which was sparked off by the violations of human rights during World War 1. The United Nations Charter was adopted in 1945 and, in this charter;

human rights were placed within the context of international law that encourages countries to respect human rights.

Internationally, the liberalization of abortion laws began primarily in the fifties and was mainly informed by the recognition of the need to reduce maternal mortality and an increased awareness of reproductive choices (Jacobson, 1990). Sarkin (1995) acknowledges that abortion law reform in many countries has been fuelled by growing pressure on governments by women's movements. At the centre of such a movement was a call to recognize women's status as competent decision-making individuals.

Liberals proposed that human rights be extended to efforts aimed at the emancipation of women. The Commission on the Status of Women was established in 1946, and it was not until the 1950s that a number of United Nations documents began to address rights issues specifically concerning women. Thus, the improvement of women's status in society has been largely spearheaded by women's social movements, particularly women's health advocates and civil movements who put pressure on governments to change policies regulating abortion (Francome, 1984; Ngwena, 1998; Pillai & Wang, 1999).

Petchesky (2003) discusses four principles that provide the foundation for understanding reproductive and sexual rights within the context of human rights. These include:

- a) **Bodily integrity** – or the right to dignity and respect for one’s physical body and to be safe from abuses and assaults including unwanted pregnancy and sex,
- b) **Personhood** – which is closely related to bodily integrity and involves the right to self- determination and respect in one’s decisions about reproduction and sexuality,
- c) **Equality** in accessing health services and all social resources; and
- d) **Diversity** – or the right to be respected in one’s group affinities and cultural differences, allowing women to freely choose and to be empowered to speak on their own behalf, and not to be subordinated to group claims in the name of tradition.

Petchesky (2003) argues that bodily integrity and personhood are encompassed in international human rights instruments. The ‘right to life, liberty and security of person’ was first recognized in the 1948 Universal Declaration of Human Rights and continued to be repeated in the International Covenant on Economic, Social and Cultural Rights (as cited in ICESCR, 1967) and various other regional human rights conventions.

In Sub-Saharan Africa, with the exception of countries in the Southern region such as South Africa, Botswana, Lesotho, Swaziland, and Namibia, women’s reproductive health issues are still poorly addressed. Human rights issues in general are also still poorly addressed as they are influenced by these countries’ socio-cultural factors. South Africa, following the adoption of a democratic system of government, has adopted a more lenient policy on abortion and a more developed policy on reproductive health care than any other country in the African continent (Packer, 2002). This followed the adoption of the

constitution which amongst other things, places priority on women's health issues, particularly issues relating to reproductive health.

The lagging behind of most African countries in implementing women's reproductive health as human rights could possibly be explained by the fact that sexuality and reproduction are practices that are rooted in the socio-cultural traditions of communities and are therefore subject to societal prescriptions. Reproductive health, therefore, tends to be a difficult form of health care to influence through the human rights approach. Women in this region, for instance, generally have limited knowledge and awareness of health related matters, lack of decision making powers and resources for seeking health care (Packer, 2002). These issues tend to negatively affect women's access to information and health care services.

Access to abortion is regarded as a reproductive right. The argument is that if a woman does not have a right to control her own reproductive life, that is, who she has sex with, when she gets pregnant, when to continue and when to end a pregnancy, then she cannot meaningfully exercise her other human rights. Reproductive rights are linked to other political, social, and economic rights. For example, women's rights to economic stability depend, upon whether a woman can postpone childbirth until she is established in a career (Widdows, Idiakez & Girion, 2006).

Pro-choice sentiments which privilege freedom of conscience and choice have largely shaped the human rights discourse. The Pro-choice position was a more liberal one,

which placed significance on the rights of women. This position was also influenced by the high mortality rates among women who complicated from illegal abortions. The pro-choice argument is that voluntary abortion is morally harmless and women have a right to choose whether or not to continue with a pregnancy. They further assert that the woman's right to autonomy and to have control over her reproductive system is more important than the foetus and its right to life (which they believe it does not possess) (Benatar, 1994) (cited in Haffajee, 1997).

Pro-choice groups argue that any legislation prohibiting women from exercising their reproductive rights, such as choosing to have an abortion, amounts to a violation of their basic human rights, particularly the right to health care. Furthermore, it has a negative consequence of increasing number of illegal abortions. The Pro-choice group further argues that the legalization of abortion on request is necessary in order to provide safe abortion services to all women (Correa & Reichmann, 1994 cited in Haffajee, 1997). This seems to suggest a causal relationship between restrictive laws and an increased number of illegal abortions.

2.4. Issues of morality and ethics

The issue of rights is fundamental to the argument of the pro-life group and the counter arguments of the pro-choice camp. The pro-life argument is that if abortion is a question of rights, then the foetus which has a full moral status also has rights that must be taken into account when making decisions about legalities of and making abortion decisions. These two counter-arguments reflect some of the struggle that societies face in defining

what constitutes normative standards for determining morally and ethically appropriate behaviour.

Joffe (1986) contends that societies struggle to define the proper relationship between the state and the private lives of the people, with sexual behaviour being at the centre of this conflict. The state becomes involved in the regulation of sexuality of its citizens through legislation. This is done through the provision (or lack of provision) of sexually related services and through ideological messages. The conflict is in terms of the different stand points of the people. Some argue that the state has no business intervening in this most private sphere of human activity, and state involvement is thus regarded as an intrusion into people's private lives. On the other hand, there are those who acknowledge the legitimacy of state involvement, however, they disagree strongly about the character and extent of this involvement (Joffe, 1986).

Where the view that values life (pro-life statements arguing for the right of the foetus) and the view that values freedom (pro-choice sentiments advocating for the right of the woman) come together, we see a clash in these values where some health professionals refuse to perform abortions for personal reasons based on religious, moral, and cultural beliefs (Dixon-Mueller, 1990). Despite the fact that the CTOP Act (Government Gazette, 1996) secures the health professional's right to conscientiously object to perform abortions based on moral grounds, this highlights the important fact that the struggle for abortion rights cannot be separated from the broader family, cultural, social, economic, domestic, religious, and political realities in which women find themselves.

Health care professionals such as those in Italy and South Africa are given the opportunity to exercise the “conscientious objection” clause. This clause allows health care workers to refuse to perform an abortion based on their personal beliefs. Governments seem to be caught between protecting the rights of women and those of the health care professionals. Khathide (2006) argues that in secular states such as South Africa, there is a tendency to place human rights above religion and culture. However, he states that this is rather difficult in a country where the majority of its people are religiously and culturally inclined.

It is important to locate the broader shifts in legal articulations of the practice of abortion as discussed above within the broader socio-cultural context. The discussion concentrates on the South African context to appreciate how the distinctive features that characterize the Choice on Termination of Pregnancy Act emerged.

2.5. The South African cultural context

2.5.1. The Pre-colonial era and customary law

As mentioned earlier, Ngweni (1998) asserts that pre-colonial African communities practiced abortion which was performed in line with customary beliefs and practices even though these abortion incidents were not legally documented. The family structures established according to customary laws had overwhelming decision-making powers and constituted mainly, if not only, of men. Customary laws promote the view of women as perpetual minors in relation to their male counterparts. Under customary laws, a woman

has to act under direction of the man and is thus not regarded as an independent thinker (Haroz, 1997). The woman's person and reproductive capabilities are transformed into parts of the man's property. Gender imbalances, women's socially defined roles and relative powerlessness increased their exposure to risk, including unwanted pregnancy (Cottingham & Myntti, 1999; Hord & Xaba, 2001). The effects of customary law have been said to be directly linked to violence perpetuated against women. Links have also been drawn between many black South African women resorting to illegal abortions as a means of gaining control over their bodies (for example Haroz, 1997). Criticism against women's relative powerlessness has informed pro-choice debates as the struggle to secure women's right to freedom took hold.

2.5.2. The Colonial era and the Roman Dutch Common Law.

Abortion was for the first time regulated in South Africa in the 17th century with the introduction of the Roman Dutch Law. Abortion was then regarded as the killing of a foetus and therefore as a criminal offence. The only exception provided for was when an abortion was performed to save the life of a woman. This exception was termed the "defence of therapeutic abortion". Only medical practitioners were allowed to perform therapeutic abortions (Ngwena, 1998).

The major limitation of the common law was that it did not clearly specify conditions under which abortion was to be performed; for instance, circumstances which fulfilled the criterion "to save a woman's life" were not specified (Ngwena, 1998, p.35). The law needed to be clarified because it was confusing for health practitioners and they could

only speculate in evaluating and interpreting the circumstances of women presenting with unwanted pregnancies.

These challenges laid the foundation for the promulgation of the Abortion and Sterilization Act of 1975 (Government Gazette, 1975). According to Guttmacher et al., (1998) and Ngwena (1998), the Act was phrased in such a manner that on the surface it appeared to empower women seeking abortion. However, in practice, the Act actually narrowed circumstances under which abortion could be procured by prescribing restrictive requirements. The new Act actually restricted and hampered access to abortion. The Act further did not make abortion accessible to the majority of South African women because the majority of women could not access abortion services under the Act for a number of reasons. Firstly, because only certain provincial hospitals and a few private clinics were allowed to perform abortions which made it very unlikely for a woman in a rural area to be referred for termination of a pregnancy, secondly, unless a woman consulted a health care practitioner who sympathized with her, it was unlikely that she would be informed of the possibility of applying for termination of a pregnancy and thirdly, even once she had accessed an abortion service, whether or not an abortion was performed, depended on whether the health care practitioner on duty is willing to perform an abortion or prefers to exercise conscientious objection and whether the hospital provides abortion services (Orr, 1995).

Even though this Act was promulgated to clarify the circumstances under which abortion could be obtained, it seems this objective was not met given Orr's (1995) criticism of its

lack of objectivity. Most commentators though, criticized the Act in terms of how it hampered rather than facilitated access to abortion services (Ngwena, 1998; Guttmacher et al., 1998; Engelbrecht et al., 2000). Ngwena (1998) notes that women, particularly Black women, found the requirements of the Act near impossible to meet.

The concern about the Act hampering access to legal abortions was related to how it then promoted illegal abortions. Engelbrecht et al. (2000 p.5) contend that “the stringent restriction on access to legal abortion had the undesired effect of encouraging illegal or ‘backstreet’ abortions, particularly among Africans and the poor”.

Ngwena (1998) puts the figure of women who qualified for a legal abortion during the operation of the Act at 800-1200. Over 66% of such women were white and from an urban, middle-class background, and this was at a time when Whites constituted 16% of the population in general. Ngwena (1998) further contends that not only were the majority of legal abortions in South Africa performed on White women, they were also in an advantaged position in the sense that they were financially able to travel to an overseas country to procure an abortion if they could not satisfy the conditions of the Act.

Affluent women, who were mainly White could also afford to pay a private practitioner to have an abortion performed (Guttmacher, et al., 1998; Ngwena, 1998). Furthermore, White women, especially the wealthier ones, had more success negotiating the requirements under the 1975 Act to obtain a legal abortion. According to Haroz (1997),

the most common mechanism for obtaining a legal abortion was to qualify under the mental health exception, which required the approval of the state psychiatrist.

Haroz (1997) states that in the mid-1980s, only twenty seven state psychiatrists were available. Those psychiatrists were concentrated in the urban areas. Thus, poor Black women in the rural areas had an extremely limited if not zero chance of seeing a psychiatrist. Even for women who could afford to get to a doctor, language barriers and high illiteracy rates among Blacks contributed to the inability to meet the requirements of the 1975 Act (Haroz, 1997).

It is therefore Guttmacher et al.'s (1998) assertion that compared to Black and Coloured women, White women had several options when an unwanted pregnancy occurred. Ngwena (1998 p.40) sums up his criticism of the Act by stating that "however, unintentionally, the Act thus created racial and class barriers to abortion". According to Orr (1995), the Act is such that in general, those who most need access to safe abortion services, that is, the impoverished, disadvantaged and disempowered women, are those who are least likely to reach abortion services, let alone satisfy the requirements.

One of the factors which also hindered access to legal abortions was in terms of the certification and administrative procedures which were prescribed for women seeking to obtain an abortion to satisfy the requirements of the Act. According to Ngwena (1998), by extending the grounds for abortion beyond saving the life of the woman, the Act liberalized the law; however, the Act employed restrictive language to specify the

prerequisite for abortion. It could be argued that a woman's right to procure an abortion was an illusion. A further certification hindrance was that an abortion could not be procured unless an application had been made by the doctor intending to perform the abortion. A woman wishing to abort had to locate a doctor willing to perform the procedure and persuade the doctor to initiate a written application on her behalf (Haroz, 1997).

Furthermore, there had to be certification by two medical practitioners, excluding the practitioner intending to perform the abortion. The two certifying doctors could not be employed by the performing doctor, and one of the two doctors must have practised medicine for at least four years. In cases of an abortion on the grounds of mental health, one of the certifying practitioners had to be a psychiatrist employed by the state. The 1975 Act thus limited the number of doctors who could perform and certify an abortion (Haroz, 1997; Ngwena, 1998).

The pregnant woman also had to seek the approval of the head of the institution where the abortion was to be performed. The role of the certifying practitioners and the head of the institution was to ascertain that the woman satisfied the requirements of the Act and this they did by interrogating a woman seeking an abortion as much as necessary (Haroz, 1997; Ngwena, 1998).

Where the pregnancy resulted from rape or incest, one of the certifying practitioners had to be a district surgeon who examined the woman following a complaint lodged with the

police. Furthermore, a magistrate had to issue a certificate to the effect that (i) a complaint had been lodged with the police, in cases where the woman had not lodged a complaint, that there were acceptable and sufficient reasons why a complaint had not been lodged, and (ii) that on the balance of probabilities, the magistrate was satisfied that unlawful intercourse had taken place (Ngwena, 1998). Ngwena (1998) contends that in essence, these provisions put the burden of proving rape or incest on the victim. What seems to be apparent here is the overriding influence of legal constructions of abortion. It seems to be taking precedence even over issues of morality.

Ngwena (1998) notes that a woman required certification by more than four doctors in order to procure an abortion according to the stipulations of the Act. The medical discourse was thus evidence-based and was obsessed with accuracy and doing things right. This excessive bureaucracy was impossible for the majority of women to proceed through. Thus, this Act served to deter rather than facilitate access to a legal abortion.

Furthermore, the Act was criticized for its lack of respect for the woman's confidentiality. For instance, immediately following the abortion procedure, the superintendent of the institution where the abortion was performed was required to submit details of the abortion, including the name and address of the woman to the then Department of National Health and Population Development (Ngwena, 1998).

The 1975 Act, gave doctors statutory authorization to refuse to perform an abortion. Any doctor who performed an abortion whereby the woman did not satisfy the requirements

of the Act or any woman who received the illegal procedure could receive a fine of 500 rand and a five year prison term (Haroz, 1997). This provision probably deterred a number of doctors from being involved in abortion issues to avoid the legal implications. Doctors could therefore refuse to be involved in abortion work based on fear of punishment or by using the conscientious objection clause. This discussion illustrates the influence of legal provisions on the medical construction of abortion.

An estimated number of illegal abortions per year was 120,000 or more in South Africa (Engelbrecht et al., 2000; Ngwena, 1998). According to Walker (1996) illegal abortions were performed every two minutes in South Africa. A 1994 report by the World Health Organization (WHO) indicates that two-fifths of all abortions are clandestine and are carried out in countries where the circumstances of the pregnancy render the abortion illegal or where the provider is not legally qualified (Basu, 2003).

2.5.3. The Democratic era and the CTOP Act

When South Africa became a democratic state, a constitution which recognized the rights of all citizens was passed. One of the major changes during this era was the statutory status of South African women. Women's reproductive rights came under the spotlight and their right to choose to have an early abortion was recognized. According to Ngwena (1998), access to legal abortions became an integral part of the national health plan during the 1994 elections. Making abortion issues part of the national health plan was a strategy to ensure that it is effected at all government levels (Althaus, 2000).

The 1994 constitution, according to Ngwena (1998 p.40), “was a mechanism to reverse a system which, through a combination of the paterfamilias traditions of Roman-Dutch law and the patriarchal orientation of African customary law, had inscribed into law a subordinate status of women”. Women were afforded a subordinate status even under colonialism and apartheid government system. Even though all women were affected by this system of government, Black and Coloured women were the most affected (Ngwena, 1998; Haroz, 1997).

The Choice on Termination of Pregnancy Act (Government Gazette, 1996) was passed in November 1996 and came into effect from the 1st February 1997. The new Act promotes reproductive rights particularly for women and extends freedom of choice by offering every woman the right to choose whether to have an early, safe, and legal abortion according to her individual beliefs (Engelbrecht et al., 2000; Althaus, 2000).

Althaus (2000) contends that when the CTOP Act took effect, South Africa became the first country in Sub-Sahara Africa in which women had the right to obtain an abortion on request during the first 12 weeks of pregnancy. The CTOP Act was hailed as one of the world’s most progressive abortion laws and South Africa as unprecedented in passing the most progressive abortion laws in Africa (Hord & Xaba, 2001).

The CTOP Act has made abortion services more accessible by allowing trained midwives to perform abortions. Previous laws allowed only doctors to perform abortions and with the current shortage of doctors, this was in itself hindering women’s access to abortion services. Allowing midwives to perform abortions in the first 12 weeks of pregnancy

implied that abortion could be accessed at the primary level of care, that is, at the clinics. Furthermore, with the previous laws, termination of pregnancy was to be performed in designated hospitals only which were, in most cases, situated in urban areas. This condition in effect, excluded the majority of poor rural women.

2.6. The role of midwives in abortion services in South Africa.

In terms of the CTOP Act, registered midwives who have completed the prescribed training course may perform termination of pregnancy for women with a gestation period of 12 weeks and less. Abortion services are cost effective when rendered at the primary level of the health care system, that is, at the clinic level and when abortions are performed in the first trimester of pregnancy. Pregnancies terminated in the first trimester are medically less complicated because the foetus is still less developed at this stage (van der Westhuizen, 2001).

Most clinics, especially in rural areas, experience a shortage of doctors, thus rendering registered nurses crucial service providers. Nurses play a particularly critical role in health care, abortion care in particular, because they are the point of first contact and are usually members of the local community (van der Westhuizen, 2001). They are therefore in a position to understand the local cultural and religious values which have a profound influence on abortion issues.

Midwives who volunteered to train as TOP service providers had to undergo intensive training which focused on training midwives to provide comprehensive abortion care services. This training took place from November 1998 to May 1999. Training involved the use of manual vacuum aspiration for first trimester abortions, the treatment of incomplete abortions resulting from pregnancies of 12 weeks or less gestational period, the stabilization and referral of women with abortion complications resulting from pregnancies over 12 weeks gestation, linking abortion services with post-TOP contraceptive services and follow-up care and linking abortion services and other reproductive health services, as needed by the women (van der Westhuizen, 2001).

2.7 The challenges facing TOP service providers

Nurse midwives providing TOP services have been found to be emotionally affected by the experience of performing abortion procedures. This happens despite having voluntarily trained to be abortion providers. Without adequate support and the lack of counselling facilities for these nurses, many of them might lose interest in the work around abortion or develop judgemental attitudes towards women who seek abortion services (Ndhlovu, 1999). The challenge is that if trained staff become discouraged because of factors such as lack of infrastructural and emotional support and being victimized and ostracized, then the implementation of the Act will be impeded, and this service might collapse resulting in women with unwanted pregnancies resorting to illegal abortions.

When the CTOP Act was implemented, the challenge was that some of the hospitals and clinics designated as TOP service points were not ready to offer the service in terms of trained staff and infrastructure. Those which were already functioning had to cope with a high influx of clients. This seems to illustrate a direct relationship between legalizing abortion and an increase in the number of abortion requests. However, this does not necessarily mean that there were increases in abortions per se, but rather that those who may have otherwise obtained the abortion illegally were given an opportunity to obtain it legally.

Even though termination of pregnancy has been legalized, it continues to be a controversial issue based on the moral, religious, cultural, ethical, and professional dilemmas it raises. Attitudes towards abortion in the general community and among some health care workers do not promote or support women's right to choose. This indicates that people's choices are not created in isolation but are created within a social fabric. TOP is thus characterized by social stigma, professional isolation and in some instances, harassment and violence against nurses who provide TOP services. This resistance towards TOP work manifests even in communities in which these providers live (Varkey, 2000). Varkey and Fonn (2000) (cited in Potgieter & Andrews, 2004) maintain that the patriarchal nature of the South African society and the general lack of awareness about women's rights contribute to the communities not supporting women's right to choose.

Under the CTOP Act health care workers are not mandated to perform abortions, or even to refer women to other providers. Their only obligation is to inform women of their rights under the new law (Guttamacher et al., 1998). This clause may be viewed as

indirectly limiting access to abortion services. It also illustrates competition in the legal discourse whereby it is the rights of women versus the rights of health care workers.

The shortage of nurses providing abortion care is an international phenomenon as supported by a study by Ventura (1999), which found that fewer nurses were tolerant of abortion, and that there is a decline in the number of nurses willing to work in obstetrics and gynaecological wards where abortions are performed. The likely explanation is that the procedure should not be necessary except in cases of rape, incest, or threat to the mother's or child's health or life. This view is probably based on the belief that there are numerous options available to prevent pregnancy. A nurse's willingness to be involved in abortion work seems to be influenced by factors such as personal choice, perceptions, and public opinion. It becomes a challenge to exercise personal choice in a matter which is generally perceived as socially unacceptable.

An exposure of nurses to abortion activities frequently resulted in an even more negative affect (Allen, Reichelt & Shea, 1997). This finding was supported by Webb (1985) who contends that nurses who have been involved in pregnancy terminations for some time tended to develop negative attitudes later. It was found that the more advanced the pregnancy, the more judgemental, moralistic, and angry the nurses became. Not adequate research studies have been conducted to explore and describe the experiences of nurses directly involved in termination of pregnancies or the support they need or receive (Gmeiner & van Wyk, 2000).

There was no psychological/emotional support available for the staff rendering TOP services (Engelbrecht et al., 2000). These nurses require psychological support through counselling or support groups to help them deal with their daily experiences of being involved in a procedure which places them in a personal, moral, religious, ethical, cultural, and professional dilemma. The fact that personnel volunteered to participate in TOP did not automatically imply that they were not emotionally affected by the trauma of performing abortions (Ndhlovu, 1999). The need for psychological support for nurses is even greater now because they are no longer merely assisting but are directly performing the terminations.

In order to try and address the negative attitudes of some health care professionals, The Planned Parenthood Association of South Africa has conducted Values Clarification workshops in hospitals that provide abortion services. The main purpose of the workshops was to facilitate effective implementation and management of abortions. The focus was also to try to gain an understanding of TOP service providers' concerns regarding abortion and to assist them in relating their values to women's needs (van der Westhuizen, 2001).

Hord and Xaba (2001) point out that the poor state of public health facilities in South Africa poses a challenge to the implementation of the Act. The public health system is currently struggling with providing basic health care particularly to the rural poor and faces high maternal mortality, inequitable access to health facilities, and an inadequate health system infrastructure. Nurses and doctors in South Africa are already faced with

being understaffed and overworked and having to incorporate abortion services into their work schedules is a challenging exercise. It therefore has the potential to lead to resentment and resistance on the part of the health care workers. The state of the public health care system thus influences the ease or difficulty with which abortion services are incorporated into the existing health care system.

2.7.1 Value conflict

A study by Marek (2004) found that abortion is one area in which many nurses struggle with conflict between their personal convictions and professional duty. The same study indicated that nurses in South Africa expressed dissatisfaction with their role in abortion. Conflicting values experienced by health professionals providing TOP services is related to the objection to and stigmatization of abortion in communities in general.

People generally do not have total autonomy in creating values that they hold. Instead, much is acquired from their social context, family, and culture. Some of the values are fostered and helped by selected educational strategies and the process of socialization to the profession (Shelley & Miller, 1991). Nurses and doctors, for instance, are trained in a context which emphasizes preservation of life. The value of preservation of life seems to be in opposition to termination of pregnancies. For instance, if TOP is regarded as the taking of life as construed within pro-life camps, this would then be in direct opposition to the values of the medical profession, in essence, and there is a contradiction in the sense that while preservation of life is an upheld value, this value is sometimes realized

by the taking of life. If the life of a pregnant woman is considered to be in danger, abortion is indicated. There is potential for value conflict. Expecting health professionals to terminate pregnancies has thus created a situation in which there is a clash of values; that is, professional, moral, religious, and social values. Matters of legality and moral values overlap. Termination of pregnancy is legalized, but that does not mean that it is morally acceptable to everyone (Shelley & Miller, 1991). It is even a more difficult position for health professionals who have to be directly involved in TOPs whereas doing so is in direct contradiction to their religious and cultural backgrounds. It is thus argued that abortion issues cannot be addressed in isolation from individuals' socio-cultural contexts and experiences.

Health professionals involved in TOP services face the challenge of being ostracized and victimized by their colleagues and communities in which they live. (Ndlhovu, 1999). This has played a part in discouraging nurses from being involved in abortion services. This situation has the potential of impeding the implementation of the CTOP Act as nurses are a critical component in the implementation process.

2.7.2 Potential for emotional burn out

The demand and utilization of Termination of Pregnancy services increased as a result of the abortion law, which made abortion services accessible and available to women from all sectors of society. The TOP Act allows women to request abortion based on social and economic reasons and in the first 12 weeks, a woman can request an abortion without furnishing any reason whatsoever (Ngwena, 1998). Considering the high levels of

unemployment and poor social conditions of the majority of women in South Africa, it is to be expected that more women will have unwanted pregnancies. The high incidences of rape and HIV infections in this country put women at risk for unwanted pregnancies and the request for pregnancy terminations.

2. 8. Conclusion

The medical, social, and economic impact of unwanted pregnancies and illegal abortions has been a world-wide phenomenon, which accelerated the re-evaluation and reform of abortion laws in many countries. This chapter illustrated some of the challenges inherent in reforming and promulgating abortion laws. It further discussed the influence of the medical, legal socio-cultural, political, and economic constructions of abortion on abortion practices.

The next chapter discusses social constructionism as a theoretical frame of reference that underpins this study.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1. Introduction

The aim of this chapter is to outline and explain the theoretical framework adopted in this study. Social constructionism is regarded as a lens which can best offer perspective on how abortion, women, and culture come to be constructed.

A brief explanation of postmodernism is provided as grounding to the development of social constructionsism. The relevance of social constructionism to the current study is also expounded upon.

3.2. Postmodernism

Throughout history, human belief systems and practices have evolved marking changes in how individuals and collectives understand themselves and what is happening around them. These processes of change reflect shifts in people's understandings of the nature of knowledge, what is knowable and how knowledge can be generated and organised. The certainty of a knowable and observable reality that exists out there, reason, and logic formed the foundational basis of the modernist context (Becvar & Becvar, 2006). Questions concerning the ills of society were guided by these assumptions.

Postmodernism emerged as a reaction against certainties, methods, and practices of modernism. The distinction between the observer and the observed is regarded as inconsequential in postmodernism since people can only describe observing systems.

Postmodernist thought is characterised by a loss of belief in an objective world and the notion that there is no one true reality. The emphasis is rather on how reality is socially constructed through language, simultaneously acknowledging how different perspectives emerge through this social and linguistic process of construction. According to the postmodern thought, people construct their views of reality through networks of social and communal connection. This implies reality is constructed through an interactive process that is subjective (Becvar & Becvar, 1996).

Such a conceptualisation acknowledges that reality is a multiverse of meanings created in a context of diverse and dynamic social exchange. This alerts us to the fact that different people may have different interpretations of the same phenomenon (Becvar & Becvar, 1996).

In postmodernist view, this inability to objectively know reality means that all that people can do is interpret experience, and given that there are many ways to interpret experience, no one way can claim to be really true (Freedman & Combs, 1996). Gergen (2000) asserts that postmodern view offers alternative visions of knowledge, truth, and the self which offer counter understandings of modernist epistemologies which regard truth as

generally fixed. Reality is rather seen as subjective and our worlds are multiverses, which we construct through observation.

The view of reality as a subjective and socially negotiated entity fails to escape from contextual politics of power. This perspective invites us to pay attention to marginalised stories in order to open up different possibilities for acknowledging how they contribute to the manner in which meaning is variously created.

3.3. Social constructionism

Social constructionism is a theoretical framework based on the assumption that social and psychological phenomena do not have a pre-given or objective reality, but are socially constructed. Reality is seen as socially constructed through interactions between people and through networks of relationships. It concerns the view that “many of the abstract qualities, our relations according to these, and the relationships of everyday life are human made processes and contexts into which we have been born, or we gain access by our credentials in society” (Owen, 1992, p. 387). Social constructionism emphasizes the processes through which people experience, describe, and explain the world in which they live. According to this view, the knowledge which people have of the world, which they express in words and deeds, is not based on subjective or innate categories or on objective observations, but on what people do together and on what connects them in these joint activities such as verbal communication (Peeters, 1996).

Social constructionism is thus fundamentally about relationships: it is communal rather than individual, sees events as being related rather than internal, and involves the creation of meaning in community with others. Social constructionism holds the premise that people construct their own reality in social interaction with others. Thus, there is no such thing as objective reality “out there”; each individual creates, intersubjectively, his/her own knowledge about self, others, and the world. Meaning is created in the constantly changing and evolving nature of social interaction (Hoffman, 1995).

Freedman and Combs (1996) posits that knowledge is generated within communities of knowers. That implies that the realities we ascribe to are those we negotiate with one another. In social constructionism, facts are replaced by perspectives (Becvar & Becvar, 2003). The researcher in this study describes the phenomenon of abortion based on the perspectives of the different service providers.

Social constructionism, followed from constructivist paradigms which is grounded on the assumption that we construct reality in the process of perceiving and describing an experience. Our understanding of how things are is a function of our belief. From this perspective, we cannot observe or know the truth about people or phenomena in the world in any objective way. Rather it is assumed that all we can know are our constructions of people and other world phenomena. Consideration of the context of language as well as its influences, introduces the realm of social constructionism. The emphasis thus shifts from a focus on mind and the constructions of individuals to the world of shared meanings (Becvar & Becvar, 2003).

The participants in this study used language to construct their reality about abortion. In addition to obtaining individual subjective accounts, there was also identification of shared meanings from the different texts by comparing themes. This reality is not fixed as it is based on the current participants' subjective experiences.

According to social constructionist views, social reality is not waiting to be discovered, but it is rather what people perceive it to be within their cultural and social frameworks. Freedman and Combs (1996) state that the lenses that we use to interpret our world and experiences are constructed by our cultural and societal experiences. Social reality that surrounds people from birth such as institutions, customs and laws, are constructed from day to day and generation to generation through interaction among members of a culture.

In social constructionist studies, researchers describe socially constructed realities through a critical analysis of texts (Terre Blanche & Durrheim, 1999). The researcher in the current study analyzed texts of TOP service providers. Based on these social constructions of reality, certain beliefs and/or practices may be promoted while others may be discouraged.

3.3.1. Assumptions

One of the assumptions of social constructionism is that knowledge and social action go together. These 'negotiated' understandings of reality could take a wide variety of different forms and thus result into a number of possible 'social constructions'. However,

each different construction brings with it a different kind of action from human beings. Descriptions or constructions of the world promote some patterns of social action and exclude others (Burr, 1995). Historically and culturally, abortion has been predominantly condemned and discouraged. The Choice on Termination of Pregnancy Act of 1996 introduced a new legal construction of abortion. The participants in the current study formulated their constructions around abortion based on their daily experiences in their work environments.

An interesting observation is that the previous legal construction of abortion in terms of, for instance, the Abortion and sterilization Act of 1975, criminalized and effectively made abortion inaccessible and unavailable; and in that sense it allied itself with the cultural, professional, ethical, moral, and religious constructions which are mainly anti-abortion. This Act can be regarded as a construction that favoured only a section of the South African community. The current CTOP Act construction liberalizes and avails abortion to women from different sectors of life.

Social constructionism further focuses on how ideas and attitudes have developed over time as influenced by social or community contexts. Dickerson and Zimmerman (1996) state that social constructionism is more interested in the narratives or discourses as people tend to perceive these as norms against which they measure and judge themselves. Furthermore, it emphasizes deconstruction of dominant constructions of reality. People could be viewed as formulating ideas and attitudes about abortion and accepting these as normative standards against which they measure their behaviour.

According to Owen (1992), social constructionist view like that of phenomenology, involves questioning, searching, clarifying, checking, and constantly re-evaluating opinions in the light of new data. Social constructionism challenges the bases of conventional knowledge by making a phenomenological inquiry into what is usually taken as a norm. In the current study, opinions and experiences of the service providers are evaluated in the light of the TOP service.

Termination of pregnancy has now been legalized, liberalized, and made accessible and available, and it is therefore imperative to constantly re-evaluate its position in the society in terms of opinions and beliefs. The aim of this study is to re-evaluate how service providers perceive and experience the abortion phenomenon. Some people might make a move from being negative about it to being tolerant of it. There might even be shifts in the very different belief systems that are supporting a particular dominant belief/normative standard. For instance, some religious denominations are now accepting gay people and even ordaining them as priests whereas, in the past, there was a lot of intolerance towards them.

Social constructionism recognizes multiple selves, multiple meanings, contexts, and perspectives and does not disregard the fact that we always exist in and are influenced by these multiple contexts and meanings (Dickerson & Zimmerman, 1996). Abortion is thus constructed socially, medically, ethically, morally, and legally. Nurses who are involved in abortion services are influenced by the different contexts in which they function.

Nurses are thus motivated by different reasons to be involved in this service. Abortion therefore does not necessarily have to have a single meaning to everyone in the community. People are allowed to create alternative meanings to different experiences. Meanings need not be fixed and prescribed, but generated through people's lived experiences.

The current author's discussion is guided by the different perspectives that conform to social constructionist assumptions. According to Cecchin (1992), a social constructionist therapist, in this case, researcher, may at different moments follow many different leaders, but never obey one particular model or theory. Based on this background, this discussion draws on views and arguments based on feminism, cultural studies, and narrative psychology.

3.3.2. Culture as a social construction

In relation to culture, social constructionism assumes that the ways in which we commonly understand the world, the categories and concepts we use, are influenced by our history and cultural beliefs and practices. This implies that all ways of understanding are historically and culturally relative and depend upon the particular social and economic arrangements prevailing in that culture at that time (Burr, 1995). In the same vein, constructions of abortion are shaped by cultural and historical influences.

According to Owen (1992), social constructionism views all values, ideologies, and social institutions as human made as they are generated during social interactions.

Relationships between people are therefore viewed and judged according to stereotypes of social institutions whose actual participants either conform to or differ from. This further implies that “facts” about human behaviour cannot exist in the absolutist sense because everything is open to dispute and differing interpretations. This highlights the view that knowledge is a social construction and, therefore, meanings of abortion are negotiated in a socially related manner. Therefore, personal values, perceptions, attitudes, and ideologies with regard to abortion are generated through social interactions. Attitudes and perceptions around abortion and the use of contraceptives are thus socially branded.

Social constructionist approaches regard people as though their thoughts, beliefs, feelings, understandings, values and experiences were the products of systems of meaning that exists at a social rather than an individual level. How individuals respond to any phenomenon or issue, abortion in this instance, is a product of existing meaning systems such as religious, professional, or cultural ones.

Social constructionist theory further holds that although the content of our thoughts is shaped by the wider social concepts and values, we do not always simply absorb them passively. We debate, challenge, question, and weigh up the pros and cons. People are represented as active thinkers, capable of exercising choice and making decisions about the strengths and weaknesses of their society’s values, beliefs, and ideas (Burr, 1995). The question then is whether individuals, by challenging societal values and exercising individual choices, can change society. This poses a problem for social constructionists because of their view of the individual as the product of society. The problem centres on

the direction of change: that is whether individuals determine change in society (i.e. bottom-up), or society determines change in individuals (top-down). According to Burr (1995), this problem arises as a result of viewing the individual and society as two components of a dichotomy. In practice, 'society' and 'individual' do not operate as separate entities even though they are often dichotomized for analytic purposes (Burr, 1995).

The researcher contends that the individual does not exist in isolation since individuals form part of a collective who share similar sentiments. It is in the context of a collective that individuals can challenge the existing cultural beliefs. Challenges are therefore facilitated from within societies in a mutually recursive manner and not in a unidirectional way. How people think about issues, make choices, and behave is generally culturally determined. Behaviour is therefore, shaped by societal values and cultural prescriptions.

Burr (1995) believes that we construct our versions of reality between ourselves within a particular culture or society and therefore denies that our knowledge is a direct perception/ observation of reality. It implies therefore that within social constructionism there can be no such thing as an objective fact because all knowledge is derived from the collective experiences of people within their cultural contexts.

Peeters' (1996) description of social constructionism is coherent with Burr's (1995) description by stating that people create their own reality. He goes further to say that

power structures, strategies of persuasion and influence, are what ultimately determine which reality comes to be adopted as the reality in a given culture.

The predominantly prevailing negative attitudes and views towards abortion seem to have been ‘normalized’ and accepted as the only ‘truth’ and perspective available in relation to abortion. This could be explained by the fact that negative attitudes enjoy the support of power and influence entrenched in culture and religion. This could probably be related to the fact that positive messages and attitudes about abortion were rarely overtly promoted. It is therefore, not surprising that the cultural stance, which is that of opposition towards abortion, seems to prevail over other possible stances.

Cultural definitions of wanted and unwanted pregnancies, abortion, and use of contraceptives differ sharply among social groups and among individuals. These differences are influenced by factors such as gender, marital status, age, religion, class, and ethnicity. The termination of certain categories of pregnancy is socially accepted or tolerated in some settings and stigmatized in others (Dixon- Mueller, 1990).

3.3.3. Narratives

Social constructionism prefers stories that are based on people’s lived experiences and their perception thereof rather than on the basis of some ‘expert knowledge’ (Doan, 1997). This study aims to highlight the lived experiences of nurses who provide abortion services. Even though social constructionism encourages individuals to tell their own stories, it also acknowledges the social nature of human life; that is, these stories are

embedded in a cultural and social context, and that they are not free of religious, moral, family, and community influences (Rapmund, 2005). TOP service providers belong to family, religious, professional, and cultural systems. Thus their experiences and perceptions about abortion is coloured by these different contexts.

Social constructionist methods in research are qualitative and interpretive, and they are concerned with meaning. According to Terre Blanche and Durrheim (1999), social constructionist researchers want to show how understanding and experiences of individuals or groups are derived from (and feed into) larger discourses. Being interested in understanding and interpreting the ‘voices’ of participants, social constructionists more often employ theoretical frameworks that make sense of situated events and experiences.

In line with social constructionism, whoever wishes to gain insight and understanding into people’s nature should not examine the psyche, but rather the linguistic interactions within the community. This view is what makes social constructionists to focus intently on the stories or narratives which people make up (Peeters, 1996). Furthermore, according to Parry (1997), social constructionists recognize the connection between stories. In this study, the connection between the participants’ stories is attained by comparing and contrasting each participant’s story with the stories of other participants. Narrative assumptions are thus compatible with social constructionists’ position in terms of making peoples’ stories central.

Parry (1997, p. 122) contends that “whenever we describe our interactions to others or to ourselves, we construct the events as narratives regardless of whether the events were past, present or future”. In the current study, the participants described their daily interactions with clients, community members, colleagues, doctors, and managers. Descriptions of these interactions are given in the form of narratives.

The generally accepted mode of social reality is language, in the form of written or spoken word. Social interaction of all kinds, language in particular, is of great interest to social constructionists (Burr, 1995). Culturally available linguistic resources are used to express views and attitudes towards abortion. According to Burr (1995), language is a pre-condition for thought. How we understand and construct our world does not come from objective reality but through learning from other people around us, both past and present.

Burr (1995) further argues that we are born into a world where the conceptual frameworks and categories used by people in our culture already exist. These concepts and categories are acquired through socialization by all people as they develop the use of language and are thus reproduced everyday by everyone belonging to that cultural and language group. This means that the way people think and the very categories and concepts that provide a framework of meaning for them are provided by the language that they use, therefore, making language a pre-condition for thought. The centrality of language is demonstrated, for instance, in the use of the concepts ‘abortion’ and ‘termination of pregnancy’. It appears therefore, that people derive different meanings

from these two words with the word “abortion” generally having some negative connotations even though the two words refer to the same procedure. The word ‘termination of pregnancy’ appears to be more acceptable, sophisticated and dignified than the word ‘abortion’.

Social constructionists highlight the idea that representations of reality such as religion, moral standards, professional standards, or cultural standards are structured like a language or a system of signs. They therefore construct particular versions of the world by providing a framework or system through which we can understand objects and practices, as well as understand who we are and what we should do in relation to these systems (Terre Blanche & Durrheim, 1999). Our views and beliefs about TOP and use of contraceptives are therefore influenced by our religious, moral, professional, and cultural standards.

Different theorists emphasize the central role of language in social constructionism. However, Terre Blanche and Durrheim (1999 p.151) warn that “constructionist research is not in the first place about language *per se*, but about interpreting the social world as a kind of language; that is, as a system of meanings and practices that construct reality”. The reality about abortion as it stands now has been created and sustained through language and the contention is that an alternative reality is possible through the participants’ spoken language as they share their experiences in interaction with the researcher. Burr (1995) asserts that the possibility of alternative constructions of the self

and other phenomena in one's world, through language, is fundamental to the social constructionist perspective.

3.3.4. Gender as a social construction

According to Ardener (1981) (cited in Owen, 1992), some feminist writings on gender roles adopt a social constructionist perspective. Feminists state that many social institutions are **man**-made and male dominated. Their criticism of male-female relations is that they largely benefit men at the expense of women. Gender analysis examines the power relationship between men and women. It enables us to examine how women's socially defined roles and relative powerlessness determines their exposure to risk, access to health care, and realization of their rights, reproductive rights in particular (Cottingham & Myntti, 1999).

According to Dickerman and Zimmerman (1996), the perpetrators of social phenomena such as abuse and violence are people who are afforded a position of power by the dominant culture. Those given positions of power by the culture (for example, based on gender, race, class, or point of view) justify what they do based on these privileging cultural narratives. Some unwanted pregnancies result from violent actions against women, for instance, rape. According to Marek (2004) and Ventura (1999), there have been reports of physical harm and victimization of nurses involved in termination of pregnancies. The point of view of the perpetrators is given a position of power by the dominant culture.

In South Africa, the interwoven systems of apartheid and customary law defined the role of Black women and severely limited the scope of these women's reproductive choices (Haroz, 1997). An imbalance of power between men and women was the most frequently mentioned reason for unwanted pregnancies (Varkey, Fonn & Ketlhapile, 2000). The limited scope of women's reproductive choices seems to have a direct effect on the use of contraceptives.

According to Hord and Xaba (2001), socio-cultural factors such as religion and low status of women in society play a role in abortion issues. Women are not in a position to negotiate safe sex or to regulate their fertility. Social constructionists emphasize the cultural component and how this influences the production of dominant accounts which are sometimes based on differences in gender, ethnicity, race, or religion. Therefore, accounts that differ from established dominant cultural standards tend to be marginalized. Feminist studies have in this regard been at the forefront of showing how women's voices have been culturally and historically subjugated. Issues that have to do with women's sexuality like having the right to make independent decisions regarding their reproductive health have over the years received distinct attention.

3.4. Conclusion

This chapter discussed the theoretical framework on which this study is based. Social constructionism emphasizes that people's lived experiences are constructed through language and are a product of our culture. Furthermore, it puts emphasis on

deconstructing dominant accounts of reality and then recreating our own versions of reality in social interactions.

The next chapter discusses the research methodology employed in conducting this study.

CHAPTER 4

RESEARCH METHODOLOGY

4.1. Introduction

This chapter discusses the methodology employed in this study. The study is situated in an interpretive research paradigm that emphasizes a focus on the internal reality of people's subjective experience and qualitative interpretation. Interpretive research is fundamentally concerned with meaning and seeks to understand the research participants' definitions and understanding of situations (Henning, 2004; Terre Blanche & Durrheim, 1999). In this case, TOP service providers become central in attributing meaning to the experiences they go through in the course of delivering this service. This study therefore, seeks to understand how they understand and define the work in which they are involved.

Interpretive approaches assume that peoples' subjective experiences can be understood by interacting with them and listening to what they tell us (Terre Blanche & Durrheim, 1999). There is therefore a need for face-to-face interaction with participants in order to facilitate a context whereby a relatively free expression of emotions, feelings, and meanings is allowed. In the same way, the current study aims to gain an in-depth understanding of the subjective experiences of TOP service providers working in public health institutions in the Limpopo Province. Therefore, phenomenological approach as a method of doing interpretive research yields potential to highlight individual participants' experiences and perceptions of their direct involvement in TOP as experienced in their

day-to-day working environment.

Qualitative research techniques are best suited to allow for the qualitative interaction between the researcher and the participants, which is necessary in interpretive approaches. Qualitative research, according to Polit and Hungler (1995), is based on the premise that knowledge about humans is not possible without describing human experiences as it is lived and designed by the actors themselves (cited in Ndlovu, 1999). The actors in the present study are TOP service providers, and it is through the sharing of their experiences that other people will begin to understand what is involved in the delivery of this service, particularly in public health institutions. It is held that the experiences of service providers are influenced by the clients that they serve, the colleagues they work with, the families and communities they come from, and the managers governing the institutions at which they are based.

This chapter is discussed in terms of the research design, participant selection, research procedure, data collection, data analysis, and ethical considerations as they pertain to the present study.

4.2. Research design: A phenomenological study

4.2.1. Philosophical assumptions of phenomenological research

The phenomenological approach to research is a type of qualitative methodology which is adopted in the current study. The phenomenological method of research explores

naturally occurring events in their contexts. It is primarily an attempt to understand the interaction between participants and that which is being researched from the point of view of those being studied (Cresswell, 1998; Valle & Halling, 1989). Therefore, as researchers we are able to gain access to the multifaceted nature and complexity of social settings as well as factors that foster relationships in such settings through phenomenological studies.

What is being researched in the current study is the experiences of TOP service providers. In order to gain this understanding, the service providers become crucial in facilitating this understanding by sharing their experiences.

Burke (2000) argues that phenomenological researchers do not generally assume that individuals are completely unique; instead, they assume that there is some commonality in human experiences and thus seek to understand this commonality. This commonality is generated in a socially related manner through networks of relationships. It follows therefore that the idea of commonality of experience influences how researchers ultimately describe phenomena under investigation. According to Kvale (1996), this requires a shift from describing separate phenomena to searching for common essences.

Phenomenology is defined differently by different theorists. According to Marshall and Rossman (1995), it is the study of lived experiences and the ways we understand those experiences to develop a worldview. It rests on the assumption that there is a structure and essence to shared experiences that can be narrated. Kvale (1996) defines it as a study

of the subjects' perspectives on their world, attempts to describe in detail the content and structure of the subjects' consciousness, to grasp the diversity of their experiences in a qualitative manner and to derive their essential meanings. The emphasis of these theorists is the identification and description of the common elements (essences) of the participants' shared experiences. In addition to describing each participant's unique experiences, common experiences across the participants are also discussed.

4.2.2. Research procedure

The researcher approached three institutions in the Limpopo province which offer TOP services and applied for permission to meet with the different service providers. These institutions were targeted because they serve a large number of people in the area. Furthermore, clients who utilize services in these institutions come from both rural and urban settings, thus allowing for variations in contexts. The rationale for conducting this study in the Limpopo Province is that most of the studies on TOP in rural areas were conducted in provinces such as the Eastern Cape and Kwa-Zulu Natal.

In total, six TOP service providers were interviewed. Kopano Health Centre has four TOP providers but only three were interviewed. Lesedi Hospital has 2 TOP service providers, and they were both interviewed. Tsohle Hospital has 2 TOP service providers and one was interviewed. The researcher directly approached one participant in each institution and the others volunteered to participate upon learning from their colleagues about the interviews.

The researcher interacted with them in order to gain information and insight concerning this service. The participants were interviewed in their respective institutions and were interviewed at the times and venues specified by them.

4.2.3. Participant selection

Sampling is the process of drawing a sample from a population. In the present study, the target population consisted of registered midwives working in an institution offering TOP services in the Limpopo Province. The intention of the sampling process in qualitative studies, according to Papaikonomou and Nieuwoudt (2004), is to identify participants who fit the requirements of a specific study. They further argue that such participants should be able to give rich and comprehensive descriptions of the problem under study. The selection of participants for the current study was guided by the focus of the study which is to explore and describe the experiences of TOP service providers in relation to their day to day interactions.

4.2.4. Data collection

Researchers using interpretive approaches, according to Terre Blanche and Durrheim (1999), rely on first-hand accounts to try to describe what they see in rich detail, and the findings are presented in language. The researcher interacted personally in the form of individual interviews with the participants to acquire first-hand information regarding their day-to-day experiences as they go about rendering the service. Their experiences were expressed through talking and (re)authored in written language.

Qualitative studies generate data that consists of people's words and require research methods that capture language. In-depth interviews are one of the most useful ways of gathering these forms of data since they allow researchers to obtain information about a participant's thoughts, beliefs, and feelings about a topic (Maykut & Morehouse, 1994; Burke, 2000). In-depth interviews were conducted in order to enter the inner lived world of the service providers in this study in order to gain an understanding of their personal perspectives about abortion.

Kvale (1996) asserts that phenomenological researchers believe that the participants can give their experiences best when asked to do so in their own words, in lengthy individual interviews, and in observing the context in which some of these experiences have been played out. The participants in the current study therefore shared their experiences in the language that they understand and can articulate. These experiences were shared through the medium of in-depth interviews which allowed for free and open expression of these experiences. An interview is also a more natural form of interacting with people and fits well with the interpretive approach (Terre Blanche & Durrheim, 1999). The researcher used communication techniques such as probing, paraphrasing, clarifying, and summarizing to facilitate the flow of the interview and to encourage the participants to reflect more on their experiences.

A tape recorder was used to capture the interview data. The researcher started the interview session by asking an exploratory question. TOP service providers were asked: 'What are your experiences of being directly involved in and performing abortions and

what are your thoughts regarding the relationship between abortion and family planning?’ The questions which followed were mainly based on the participants’ responses. The participants were allowed to address the area of study based on their experiences. Each interview lasted more or less 45 minutes, and this was in consideration of the fact that the interviews were conducted during working hours.

The reliability of the study was enhanced by conducting the study in Sepedi, which is a language used and understood by the participants. Using the participants’ mother-tongue facilitated their ability to adequately articulate their thoughts without any linguistic barriers. Furthermore, audio tape records were used to capture the conversations, ensure that no important data are lost, and verify interpretations during the analysis process.

4.2.5. Data analysis

Marshall and Rossman (1995) define information analysis as a process of bringing order, structure, and meaning to the mass of collected information and as a search for general statements about relationships among categories. In phenomenological research, the researcher attempts to reduce the statements in the interview data to the common core or essence of the experiences as described by research participants (Burke, 2000).

A thematic analysis method was used to analyze information. Thematic analysis involves identifying the common themes from the information and using excerpts from the information to substantiate those themes (Rapmund, 2005). Therefore, in a thematic analysis, one looks for patterns that emerge within transcripts.

The central goal of interpretation, according to Terre Blanche and Durrheim (1999), is to discover regular patterns in our data which are broadly termed "themes". Looking for commonalities in the participants' accounts is not enough. In interpretive research, one may have to look for differences as well. This is further emphasized by Terre Blanche and Durrheim (1999) who warn that in deriving themes, we intuitively tend to look for general themes. In so doing; we necessarily overlook certain contextual differences in the things we are comparing.

The process of data analysis primarily started during the interviewing stage. By personally interviewing the participants, the researcher started to gain a basic understanding of the meaning of the data. The researcher then personally transcribed the information on the audio tape recorders verbatim. This transcription process further enhanced the researcher's understanding of the interview data. The transcription process was followed by a process of repeatedly reading each participant's transcript in order to become familiar with the data. In the process, meaningful statements, comments or words were identified and highlighted.

Groups of information in the texts which raised similar concerns or issues were organized into themes. Coloured marker pens were used to group these themes whereby all information relating to a particular theme was highlighted in a particular colour.

The inferred themes were further analyzed in order to explore the possibility of

alternative meanings and to search for headings which overlapped. A final list of themes for each participant was formulated. Once each transcript was completed, the six transcripts were compared in order to identify commonalities and differences. The experiences of the TOP service providers were thus (re)authored and recounted from the researcher's perspective. In line with social constructionist thinking, reality was co-constructed by the participants and the researcher.

4.3. Ethical considerations

The researcher requested permission from the Department of Health, and an ethical clearance report from the university was obtained before commencing with the study. The researcher ensured that participants' privacy, anonymity, and confidentiality were protected. These issues were discussed before the study commenced where participants were briefed about the study, and thereafter requested to sign an informed consent form, which clarified the aims and purpose of the study. Confidentiality was guaranteed by making sure that the interviews were conducted in a safe and private environment. Confidentiality was further ensured by identifying participants and health facilities where the interviews were conducted through the use of pseudonyms.

4.4. Conclusion

This chapter outlined the methodology which was followed in conducting this study. The chosen research design enabled the researcher to achieve the purpose of the study. The purpose of the study was to explore and describe the experiences of TOP service providers.

The next chapter will discuss the results of the study. The results are presented in the form of themes inferred from each transcript.

CHAPTER 5

PRESENTATION OF RESULTS

5.1. Introduction

This chapter presents results of the interviews. The background information of each participant is presented first to ground the process that was followed to identify the different themes contained within the interviews.

5.2. Background information

Agnes is one of the two service providers at Lesedi Hospital. She was trained in 2006 and started being involved immediately after training. Betty is also a service provider at Lesedi Hospital. She was trained in 2000 and started being involved in TOP the same year. The TOP service at Lesedi Hospital is situated in a gynaecology ward. Carol is one of the two service providers at Tsohle Hospital, and the third one is still undergoing training. She was trained in 2004 and has been practicing since then. The TOP service at Tsohle Hospital is situated in a gynae out-patient clinic. Dolly is one of the four service providers at Kopano Health Centre. She completed her TOP training in 1998 but was not placed at a TOP site. She started being involved in TOP work in 2006. Gladys is a service provider at Kopano Health Centre. She started being involved in TOP service in 2002 after completing her training. Helen is also a service provider at Kopano Health Centre. She started being involved in abortion work in 2006. The TOP service at Kopano Health Centre is located within a maternity ward.

5.3. Basic themes

5.3.1. Betty

5.3.1.1 Rejection/isolation *versus* acceptance/belonging

Betty's isolation is expressed in the form of not being supported by managers in high positions. However, she seems to experience acceptance from immediate supervisors and the Department of Health's provincial office. She said: *"In the hospital there is no support. But at least in the ward where I am working, there is support. There is support from the unit manager and the head of the section, those do support me and I do not experience problems with them. But in terms of top management, they do not even care. They only come here if there is a problem.....but provincially, they do support us. They organize debriefing sessions for us once a year"*. As a way of dealing with these difficulties at work, she said: *"When I go off, I forget everything about work related issues"*.

Betty also highlights issues of rejection with regard to clients as she attributes some women's decision to stop using contraceptives to fears of being rejected by their partners. She commented: *"Some clients will say that they stopped using a contraceptive method because their partners started experiencing problems.....erectile problems"*. Furthermore, the fear of rejection for clients appears to stem from their perception that contraceptives cause them to gain weight and also that they may later in life experience difficulties in conceiving, and this might lead to them being rejected by their partners. Her sense of acceptance and belonging seems to be enhanced through interaction with other TOP service providers. This is demonstrated by the following comment: *"We do*

give each other support by phoning one another and feel better afterwards. For me it is even better now because we are two providers now and we share our problems as we go along. Last year I was alone and no one understood my language, but at least this year I have someone to talk to and understand what I am talking about”.

5.3.1.2. Attitudes

This theme seems to be closely related to the theme of rejection and acceptance. She seems to experience peoples’ negative attitudes as rejection and positive attitudes as an expression of acceptance.

She seems to perceive church priests as having negative attitudes towards abortion. This seems to make her feel rejected by the church.as reported in her claim: *“I am no longer going to church because once they start preaching.....if the preacher starts preaching and condemning abortion, I felt like he is directing that to me. So I just stopped attending and stayed at home”*. She also highlighted negative attitudes from colleagues years back at an institution she worked at before working at Lesedi Hospital. She seems to have experienced their acceptance as conditional and situational as demonstrated by the following comment: *“Yes, where I used to work before here, people were resistant. People would say negative things about me.....but the very same people who would pray for me like that, phone me at night to ask for help when the situation has turned against them”*. Her sense of being conditionally accepted appears to apply to the hospital managers as well. She commented: *“.....maybe if they (managers) hear that a client has complained or something or if one of their relatives needs help, it is then that they*

come. That will be the first time they will be meeting me, otherwise, no!” However, she appears to perceive her colleagues at Lesedi Hospital as having a positive attitude and thus demonstrating acceptance. She said: “.....*but here, no, I haven’t experienced any resistance”*.”

Betty described her family’s attitude as having been negative initially. However, she seems to be experiencing them as accepting of her abortion related work. She commented as follows: “*Initially I could not even discuss with my family what I am doing at work, what type of work I do..... My mother initially felt that it was wrong to perform abortion, but at the end realized that it was part of my work”*.”

Betty also seems to make an association between providers’ attitudes and clients’ compliance with contraceptives. That is, if there is a healthy relationship between clients and providers, clients will be motivated to come for contraceptives. If clients experience providers’ attitudes as negative, on the contrary, they are likely to default. She says: “*That (comprehensive reproductive health services) would also help in building rapport with clients. Clients would know that if they go to such and such a centre, they would be attended to by so and so, who is friendly and willing to help, unlike going to a clinic, for instance, young girls when they go for a method, some providers ask them which family they are planning at 14 years. Those are some of the issues leading to teenagers falling pregnant. Some are told to bring their mothers along”*.”

5.3.1.3. Blaming

Betty's story demonstrates issues highlighting instances of self-blame and blaming of others. Her self-blame is demonstrated by the following comment: *"As a service provider, I feel that if a woman comes for a repeat abortion, I have failed. I have failed to give information.....Generally, seeing a repeat is not nice, you feel something was not properly done"*. She also seems to blame family planning providers for not fulfilling their responsibility of educating clients about contraceptives. She said: *"Family planning providers, that's where the problem lies because people still come here and say that they have stopped using an injection because their menses stopped.....so people then stop using the method because they were never prepared for side effects occurring....."* . Clients are also blamed for not taking responsibility for their reproductive health. This is demonstrated by the following statement: *"Also, there are problems with clients themselves, they do not seek information. They also follow what other people are saying to them"*.

5.3.1.4. Commitment

Betty's response to the possibility of her attitude towards TOP changing in the future is as follows: *"Eish, I don't think that I will change. I don't think that there will be a time where I will not want to perform TOPs.....unless if....I just don't know.....but for now I see myself providing this service until I retire. I don't see myself stopping unless if I am given a higher post outside of this, but just stopping, no!"* Her involvement in the TOP work seems to have been influenced by this experience: *"I decided to be involved because I was working in a gynae ward and I was seeing women coming with*

complications from undergoing backstreet abortions". Her commitment seems to be maintained by the reactions she observed from some of her clients. She said: "*Seeing the face of a woman who had just had her pregnancy terminated, seeing the happiness in her face.....They become relieved*".

5.3.1.5. Competence and confidence

It seems that the more practical experience Betty gained, the more competent she became. This made her feel confident as a result.

Betty's gradual acquisition of experience in performing abortions appeared to boost her levels of confidence as demonstrated in the following statement: "*Now I feel more experienced. When I started, I was inexperienced and things were going very slow.....so I gained a lot of experience. It is now easy for me to perform a TOP*". These high levels of confidence were possibly a motivating factor for her to continue in the service. She claimed: "*I feel that I can go on and on. I feel that I am doing a good job*". Even though she seemed to feel confident, competent and committed, she also expressed a need to be affirmed and recognized. She said: "*The thing is, I feel that TOP providers resign because we are not being recognized. We work so hard and do work that most people don't want to do, but nobody recognizes us.....*" This statement also illustrates a sense of discouragement.

5.3.1.6. Personal crusade/mission

Being involved in abortion work seemed to be a personal mission for Betty. She took it upon herself to assist women who found themselves having to deal with an unwanted pregnancy. This is demonstrated by the following statement: “.....*I also tell them that if I find anyone telling a client who needs a TOP that what she is doing is a sin, I will personally take upon myself to assist that client to sue such a person.....Yes, even in the hospital, if there are seminars or such occasions, I ask them to give me a platform to address and inform people about TOP. I tell them that if they spot a client who needs TOP, they must refer her to me*”. As a result of this personal mission, she also tended to sacrifice for the sake of clients. She observed: “.....*Sometimes I do not get to go for lunch because I do not want clients to go home without being attended to, and what do I get in return?....Nothing!*”

5.3.2. Carol

5.3.2.1. Rejection/isolation versus acceptance/belonging

In expressing the acceptance by her family, Carol reported: “*There is no problem family wise. They are aware of what I am doing and what is happening. There is no problem.....*” The support from doctors and hospital managers appeared to foster in her a feeling of belonging and the perception that they cared and valued the TOP service. This is illustrated in the following comment about doctors: “*We work very well together*” She went on to say: “.....*We are not short of doctors who are willing to help*”. With regard to managers, she said: “*Management supports us.....The General Manager especially, does come to check and see that things run smoothly.....The Head of*

Department was here checking how the service is running". This may also be an illustration of the inclusion and acceptance of the TOP service into the health care structures. However, she was concerned that some clients might be experiencing the fact that they could not be terminated the same day they came to the hospital as rejection. She said: *".....Yes, they do come with that attitude. They take it like we do not want to help them"*.

Negative remarks from people used to make her feel rejected and condemned, however, she seemed to have found a way to cope with those feelings. She tended to cope by convincing herself of the following: *"If I am 'Lucifer' and killing babies and that I won't go to heaven.....but what I am doing my heart tells me it's the right thing to do for my community.....as long as I have never stabbed a child to death, I do not worry and I will never be arrested for this. What I am doing is legal"*. She coped by considering the legal aspect of abortion over the moral aspect of it. This could therefore be understood as her dealing with this dilemma more on an intellectual level than on an emotional level.

In interacting with and sharing her experiences with fellow TOP providers, Carol experienced a sense of being understood and accepted. The sharing of these experiences served as an emotional outlet for her. This is demonstrated by the following comment: *".....If I feel that I am not Okay.....initially we were 2 providers, we now have a third one.....and if you feel somehow, you can talk to one of the providers and feel better. We will be there expressing our feelings, we hear all sorts of stories....."*

5.3.2.2. Attitudes

In comparing the rate of utilization of abortion services years back and now, she said: *“.....Now people do come as soon as they miss one month’s period. I think that people are now informed and utilize this service. Back in 2004, few people came.....”* This may be an illustration that the resistance towards abortion is gradually declining. In expressing the sense of rejection she experienced years back as a result of people’s negative attitudes towards abortion she noted: *“Years back, like in 2004, they would even call you names like ‘Lucifer’, you are going to Satan and some not even talking to you and so on.....”*

She further highlighted issues of attitudes by attributing teenage pregnancy to the negative attitudes of family planning providers. This is illustrated by this statement: *“.....people do come, even school children. Some say that at the clinic nurses shout at them and say all sorts of things.....and here we perform TOP from 11 years upwards, so can you see that if a child comes and says that she is sexually active.....and you ask such questions, she will come back being pregnant.....we are told not to bring our attitudes into these issues.....”*.

5.3.2.3. Secrecy

Closely related to the theme of attitudes is the theme of secrecy. It appears that as people’s attitudes towards TOP improves; the secrecy around it becomes less. Carol demonstrated the gradual openness towards abortion by saying: *“Now*

people.....around 2004 people were not open about it”. In relating an incident whereby her closest friend died following complications of backstreet abortion because she had kept her pregnancy and the abortion a secret, she reported: “.....I was very close to her and didn’t even that she was pregnant until the last moment when she died.....”.

5.3.2.4. Personal mission/crusade

After witnessing women dying from complications of backstreet abortion, Carol made it her personal responsibility or mission to be involved in abortion work. She said: *“.....So, I just thought from the experience that I had, from the patients that I have helped before in different hospitals from complications of backstreet abortion and others dying from that. I just thought to myself that I must get involved and help the community.....So, it is just something at the back of your mind that pushes you to say, ‘I am going to be there for these people’”.* She probably felt helpless at the time but now with abortion being legalized, she felt that by being involved she could help control the situation.

5.3.2.5. Blaming

Carol seemed to perceive family planning providers as not taking responsibility in the way that they execute their duties; as a result, abortion requests increased. Her blaming is demonstrated by the following statement: *“.....it is not right to chase teenagers away telling them to bring parents along or asking which families are they planning.....but you as a nurse doing nothing to exclude pregnancy.....is it maybe because they are*

alone in those settings, doing as they please.....”. She emphasized the family planning providers’ negative attitudes as playing a critical role in discouraging clients from utilizing these services.

5.3.2.6. Commitment

The fact that she reported negative attitudes from some people but continuing to be involved in the service, demonstrates her commitment. This is illustrated by this: *“.....but if you are doing something that you really want to do, no one is going to stop you from doing it”*. Her commitment is also evident in her saying: *“We volunteered because we wanted to. We were never promised any extra money”*.

5.3.3. Dolly

5.3.3.1. Rejection/isolation versus acceptance/belonging

Dolly’s acceptance of TOP clients and her willingness to be involved in the service seems to stem from her own personal experience with an unwanted pregnancy. She did not want other women to experience what she experienced. She said: *“I do not see anything wrong with abortion because I personally had an experience of not having had a chance.....People these days have a chance to do TOP. In my time we did not have that opportunity”*. She also seemed to experience her family and colleagues as supportive and accepting of her involvement in abortion work. She claimed: *“At home I do not have problems. They are supportive. They are aware of the type of work that I am doing”*. She described her colleagues as supportive because they attended to clients when she was not at work by phoning her and attending to the clients’ requests.

Dolly raised concerns about the situation which she viewed as isolation and rejection of TOP clients. She pointed out: “.....Also if I am busy with TOP clients and a maternity case arrives, I then have to stop attending to the TOP client to attend to the maternity client because TOP is not an emergency. When it comes to a push, TOP clients are the ones to be sent home and come back some other day because I cannot leave a woman in labour to perform TOP. She continues to say: “Where we do TOPs is a labour ward, so if there are patients in these wards, once termination has been done, that client has to go and sit on a bench and be checked later and discharged. So, it is not proper, we are just forcing issues to have TOPs here”. These incidents may result in clients experiencing a sense of not belonging.

Dolly also appeared to experience herself as working in isolation and this situation seems to limit her main source of support. She commented as follows: “.....So, I am alone but there are others here who are trained but are not in here all the time. They only help when I am not here. Basically TOP clients are my responsibility. This is the third month that I am alone”. Her statements show a feeling of being burdened and overworked.

Her perception of the managers’ support and acceptance seemed to be paradoxical in the sense that for as long as managers do not get involved in or monitor the service, she perceived that as support. She argued: “Management.....I can say that there is support because they do not stress us about anything. If you need something they do provide even though one can see that they do not want to be involved. They are not involved and do not

even know what we are doing here. But they are not against us; they just do not know what is happening". This perception could also be understood as stemming from a feeling of desperately wanting to feel accepted.

5.3.3.2. Personal mission/crusade

Dolly appeared to view her involvement in abortion work as a personal responsibility or obligation. She said: *".....I also feel that if I don't do it, who is going to do it even though sometimes I see it (abortion) is not right"*. It sounded like even though abortion appeared to be creating moral dilemmas for her, she felt that she had to play the role of a saviour. The following comment also highlights possible moral contradictions for clients: *"Yes, because this side we are doing TOP and that side, deliveries. How do these people feel then? It can be traumatic to some people. Some may feel uncomfortable"*.

5.3.3.3. Frustration

Dolly's feelings of frustration and helplessness seemed to have negatively affected her performance at work. She appeared to feel that she had no control over the situation and what was happening to her. She said: *"Sometimes it becomes very difficult. Sometimes I feel like I am losing my mind. Sometimes you find that it is so full and most of them are first time clients and then I ask myself and them as well 'What is happening with family planning'..... You find that I perform about 3 TOPs and I feel that 'no, I can't anymore'. I then tell them to go home and come back the following day....."* It appears that she tended to deal with the frustrations and emotional difficulties in her work environment by physically removing and emotionally distancing herself from the source of stress. She

claimed: “.....*After seeing such things, I tidy up everything and stop and tell the others in the queue to go home and come on another day. I then proceed to do other different tasks*”. Her feelings of frustration seem to be fuelled also by her perception that clients were not taking responsibility for regulating their fertility. She argued: “.....*If it is teenagers I understand, but now you find people who are old enough to be responsible. Sometimes they come twice, thrice.....you see! Which means that they don’t care about contraceptives and condoms.....People are just giving excuses for why they fell pregnant.....*” Even though she appears to blame clients for not being responsible, there are also elements of self blame. Her self-blaming and self doubt is demonstrated by the following statement: “*So, I don’t know whether we are failing or what because these days we tell them about contraceptives.....so I don’t know if the problem is with us or with their understanding.....It seems to suggest that there is something we are not doing right. I have no idea what it is*”.

5.3.3.4. Ambivalence

Dolly’s story was characterized by ambivalent feelings towards different issues in her work context. The one issue is related to teenagers undergoing TOP. On the one hand, she seemed to believe that they were the ones who needed the service. On the other hand, she seemed to condemn their right to choose to have TOP. With regard to supporting their utilization of the service, she said: “*With the kind of experience that I had, more especially with teenagers, I do not feel that there is anything wrong with those who undergo TOP*”. Teenagers are most likely the ones who would be having their first child, and this is her sentiment about women having their first child: “*I do not feel that if a*

person is expecting her first child she should terminate because sometimes you find that this person does not have experience of what is going to happen". She went on to say, "If it is teenagers, I understand". However, in the following statement she appeared to be opposing teenagers' choice to terminate pregnancy: "I think government should find a way of dealing with this problem of teenagers. Something should be done about children having choices".

To some degree, this ambivalence seems to apply to TOP in general. She said: *"I also feel that if I don't do it (TOP), who is going to do it, even though sometimes I see it is not right.....Abortion is not OK. It is not the right thing to say but then everyone has a reason for requesting it"*. Her story seems to be characterized by contradictions in terms of her appearing to be pro-choice but at the same time challenging that stance when it comes to children, and this seems to be influenced by her moral stance. However, she seemed to use the legal status of abortion in order to justify her involvement in abortion work and deal with these contradictions. Her involvement in abortion work could therefore be said to be more on a legal rather than on a moral basis.

She might be experiencing ambivalence in terms of prioritizing her needs over the needs of clients. The following statement seems to suggest that ambivalence: *"There are psychologists available but there is no time to consult because there are clients who are booked everyday. Also if I don't come to work, their pregnancies advance and when I come back, their pregnancies are advanced and what will I do to help in that case? So, where will I get the chance to go and consult a psychologist?"*

Having to be involved in issuing of contraceptives and at the same time having to perform TOPs appears to put her in an ambivalent position as well. She probably perceives this situation as sending contradictory messages to clients. She argues: *“In my view the relationship is biased, because you know, me being here performing TOP, I am also supposed to provide contraceptives. But now if I give client information about contraceptives, the next thing the very client comes to me to terminate and I am then supposed to perform TOP. Do you see now that I am saying to these people that even if they do not use contraceptives I give them, they can come for TOP?”*

5.3.3.5. Commitment

Dolly’s commitment is demonstrated by the fact that she decided to be involved in TOP at a time when it had just been legalized and not many nurses were keen to take up the challenge of performing abortions. She claimed: *“Eish! Like I mentioned before, everyone here at work has a particular passion.....I was in the group that was trained in 1998.....what keeps me going is that I do what I like doing.....”*. Her sense of commitment seems to overshadow and help her deal with her feelings of ambivalence.

5.3.4.1. Gladys

5.3.4.2. Rejection/isolation versus acceptance/belonging

Gladys’ comment may be interpreted as indicating the isolation of abortion clients. This situation may also be experienced by providers as creating uncertainties and confusion. She commented as follows: *“Sometimes we experience problems, for instance, you find*

that you are still attending to a TOP client and then a maternity case comes with a 'head on perineum', you are then expected to leave the TOP client and attend the maternity case.....".

Her story also highlights clients' fears of being rejected by their partners. She said: *"When you enquire how come they are not using contraceptives, they will tell that contraceptives make them fat and say a whole lot of other things".* With regard to the acceptance by her family, colleagues and the community members, she noted: *"I have never experienced people who condemn me or what. Even nurses, I can say that they are used to it now because I have never experienced negative reactions from them".*

She seemed to experience nurses who were not involved in TOP work as judgemental and rejecting. She said: *".....So, when you speak to another nurse who is not TOP trained, she won't listen to you with empathy. She will tell you 'Why are you doing those things', because she does not understand why you are doing it....."* This seemed frustrating for her because of feeling that she was not being understood. On the contrary, she appeared to experience a sense of connectedness with fellow TOP providers. She explained as follows: *"We are in a better position because there are a number of us here; we talk to each other as colleagues. If there was something that scared you or disturbed you emotionally during the procedure, by just being listened to, you feel better. I feel for those who are working alone in their institutions, how do they cope?"* Sharing her experiences with those who are in the same situation as her seems to foster a feeling of

universality and of being understood. This could be one of her ways of coping with her daily struggles at work.

5.3.4.3. Frustration

Gladys' main source of frustration appears to be the lack of psychological support from management considering that they work in an environment which they perceive as having a negative impact on their psychological well-being. She expressed her frustration by saying: *".....The only problem I experience is with management.....I think that management should attend value clarification workshops for them to understand how TOP works because they do not.....Most of them do not understand that sometimes we become psychologically affected.....They do not understand that we must all get that debriefing because that work is stressful....."*. It appears that because of the perpetual feelings of frustration, she sometimes developed negative feelings towards clients. This is illustrated by the following comment: *".....We get irritated when we have to perform it (TOP) on many people and you find that the person just says that they stopped contraceptives because there were side effects"*. She could also be displacing her anger and frustration onto clients. She also perceived clients as being frustrated by the system. She said: *".....after queuing for a long time to get a method, people end up leaving without it and then they fall pregnant....."*

5.3.4.4. Blaming

Gladys seems to be of the view that family planning providers and the current system of working at her institution are responsible for the rise in abortion requests. She argued:

“My view is that, we, as service providers (family planning), no longer explain things properly to clients. We are seeing that TOP is very high these days”. With regard to the system of working, she said: “Previously, one could find family planning there, immunization there.....but now you have to see different conditions and everybody at the same time.....and you don’t get time to explain that this method works like this and that”. Gladys went on further to blame clients as well for not taking responsibility for their reproductive health. She concluded: “.....but they could have used family planning.....”

5.3.4.5. Personal Crusade/mission

The experience of witnessing women dying of complications of illegal abortion seems to have driven Gladys into taking abortion work as a personal responsibility. She claimed: *“.....So, I decided that I should be involved so that people can have abortions in a sterile environment. I saw a number of people who bled to death”*. Being directly involved probably gave her a sense of control over the situation compared to previously when she could not help these women. Even though she had volunteered to take this responsibility upon herself, she felt that there should be financial compensation for the psychological turmoil that she and the others experienced. She argued: *“.....TOP work is a ‘scarce skill’ and maybe they could consider paying us for it. We would feel better because not everyone can do it and like I mentioned, we sometimes become emotionally affected.....”* In this situation, it would seem like being externally rewarded and appreciated would also serve as an encouragement into continuing to be involved despite the challenges and difficulties experienced.

5.3.5. Helen

5.3.5.1. Rejection/isolation *versus* acceptance/belonging

Helen appears to experience other nurses' attitudes as negative and thus making her feel rejected and judged by them. She said: *".....I have been labeled so many things.....This is the one that kills, but I don't.....I don't feel guilty....."* She went on to say: *".....I only have problems with my colleagues, especially the 'Born Again Christians', those are the people....."*. However, she seems to be utilizing the support of fellow TOP providers to deal with this sense of rejection and isolation. She illustrated this by saying: *".....We, ourselves, as service providers, give each other support.....We, TOP providers, we are a team. Even a colleague from another clinic, if I experienced 1, 2, and 3 that day or something bothered me, we support each other"*.

Helen appears to be of the opinion that the abortion service and clients are being rejected and isolated particularly by the management. She explained as follows: *".....now we don't have enough space. After working on a client, she goes out to lie down. Can you see how traumatic that is for them?"* She expressed her sense of the management's disregard for and lack of commitment to the service by saying: *".....Lack of equipments, for instance, if we place an order, no one is interested to process it. Sometimes they do not allocate you in this ward and there is no one to provide the service. Like now, they have allocated just one person.....They do not care if the service is running or not.....They do not care if the clients get the service or not"*.

She also appeared to perceive the service providers as being rejected as well because they did not get any emotional support from managers. She alluded to this concern by saying: *“For them to just check on us. Check if we are fine.....so, for such experiences, because one feels disturbed, when I go to management and say something happened, because I can’t tell them and I ask for leave, they will pass comments like: ‘it means you came out with a baby’. You see, we need emotional support.....The thing is, managers do not like anything to do with TOP.....”* These statements seem to suggest that there is a yearning for acceptance and a sense of belonging. Furthermore, she seems to be highlighting the insensitivity of managers to the emotional disturbance that they experience.

5.3.5.2. Fear

Helen’s statements could be understood as suggesting that being a Christian and being involved in abortion work sometimes evokes in her fears of being rejected by God. Furthermore, she seems to deal with that fear by justifying her actions by focusing on the purpose or benefits of her behaviour or work. She asserted: *“.....I regard myself as a Christian. I just told myself that I don’t see myself as committing a sin. I see myself helping people..... So, people can call me names, but even God knows that I am doing this not with an intention of killing but with the intention to see the person progress in life.....”* Helen’s focus on how others benefit from her work regardless of the discomfort and contradictions that she seems to be experiencing may be her way of coping with the challenges of her work. Furthermore, a sense of seeking approval from God to continue being involved in this work may be an illustration of how she uses her religion to cope

with this dilemma. Paradoxically, she appears to perceive management as using God to justify their rejection of abortion. She argued: *“They look at it (abortion) through their Christianity”*.

Helen also interprets the reasoning behind those who quit the service as resulting from a fear that God is possibly demonstrating His rejection of them through punishment. She said: *“.....You find that a person has been working well and when something bad happens in their lives, they start thinking that maybe God is really punishing them. So, some left because of such things”*. She also expressed clients’ possible fears of rejection and isolation in the form of the fear of being stigmatized by saying: *“They cannot go to their nearest TOP services because they are afraid that they might meet relatives or somebody who knows them”*.

5.3.5.3. Blaming

Helen expressed her frustration related to the increased rates of abortion requests by blaming both the clients and family planning service providers. She argued: *“You know these days clients are increasing.....We are giving information but still most of them are not condomising.....”* She went on to say: *“We should not give a method without explaining how it works.....I see it (family planning) as failing on our part of giving information”*

5.3.5.4. Personal crusade/Mission

She appears to have been motivated to take a stance against deaths resulting from backstreet abortions and to eliminate the secrecy around abortion as a result of personal experiences in her family. She said: *“I had very bad experiences in my family. I had 3 of my cousins whom we buried because of backstreet abortions.....They were pregnant and they could not tell their parents.....”* She seemed to regard herself as one of those who need to take a stance and volunteer to be involved irrespective of the challenges involved. She argued: *“If all we nurses become scared that we will be labeled, who will help the people. They are going to die, even our children.....”*

Helen’s decision to take abortion work as a personal responsibility also seems to stem from an attempt to avoid guilt feelings of seeing people continue to die from complications of backstreet abortion. She commented: *“.....If we all refuse to do TOP, then one day it will be your relative who has done backstreet abortion and that’s when you’ll see the importance. You will feel that you should have been there to offer the service”*

5.3.5.5. Commitment

In demonstrating her commitment to the service Helen stated: *“.....It is something that I like.....As long as TOP is still legal, we are going to continue to provide.....If they open something like a TOP clinic, we will gladly go and work there.....”*

5.3.5.6. Competence and confidence

Helen expressed how fearful and anxious she felt before she became competent and confident by saying: *“Eh! You know, my experience is that.....you know that when one is not competent enough, then one has fears and you feel like, ‘No, I won’t be able to do this’.....but now I can manage the unit on my own.....I no longer have fears. I am competent in my work.....Instead, I am marketing the service”*

5.3.6. Agnes

5.3.6.1. Rejection/isolation versus acceptance/belonging

Agnes’ statement demonstrates a plea for acceptance from management. Having a working relationship with managers seems to be of paramount importance to her. She interpreted management’s actions as isolating them as providers and the TOP service. This is evident in this comment: *“Also support from management, if they could support us because some do not even know what is happening in this service because they do not even visit”*. She went on to say: *“Support, for instance, when working in other wards, they sometimes come to check patients, wanting to know how patients are doing”*. She expressed her family’s acceptance of her involvement in abortion work as follows: *“I explained to them and they do not have any problems. They realize that it is work like any other.....”*

5.3.6.2. Commitment

Agnes emphasized her commitment to the service despite the challenges that she faced by saying the following: *“I do not think that I will ever change because I am determined to do this and I realize the importance of doing this.....”*

5.3.6.3. Competence and confidence

She appears to be still in the process of gaining experience and thus competence and confidence. This is illustrated by her saying: *“I do not have a problem working here, especially because I am gaining experience because it is not long since I qualified. So, I feel that as we go along practicing, I gain more experience”*

5.4. Conclusion

This chapter outlined the results of the study and described the themes from interviews. The next chapter discusses the results, conclusions, recommendations, and limitations of the study.

CHAPTER 6

DISCUSSION, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

6.1. Introduction

This section provides an integration of themes that emerged from the interviews. Discussion of these themes is used to address the overall objective of the study, which is to describe service providers' experiences of providing TOP. Despite some themes emerging frequently in many interviews, no attempt was made to look for a consensus or to make generalization of the results of the study.

6.2. Discussion of results

The results of the current study indicate a number of common themes identified from the participants' stories. These themes include the following: rejection/isolation *versus* acceptance/belonging, blaming, commitment, personal mission, and competence and confidence.

The theme of rejection and isolation *versus* acceptance and belonging seems to be the more predominant and pronounced of all the themes. The participants in this study seem to be continuously struggling with issues of rejection and isolation. The isolation and rejection seem to be experienced mainly in the work context. In this study, participants constructed their experiences of isolation, rejection and acceptance based on their interaction with managers, doctors, other health professionals, clients, families and

communities. This process illustrates social constructionist emphasis on interpersonal relationships and how meaning is created during these social interactions.

A commonly cited concern in the current study is about the perceived lack of support from managers in the health institutions. This lack of support seems to be experienced by the participants as rejection and isolation. This experience of being rejected and isolated is raised by five of the six participants. Participants complain about lack of emotional support particularly from the top level managers. Some cite managers who pass negative remarks and some mention the issue of not being allowed to attend debriefing sessions. This is a similar finding to the findings of Engelbrecht et al. (2000) where they reported that there is no psychological/emotional support available for the staff who are directly involved in providing TOP services.

The stories of most of the participants in this study highlight the isolation and rejection of the TOP service and its clients, for instance, in terms of the lack of equipments and resources to render the service effectively.

All the participants complain about the lack of space to work. At Kopano Health Centre, for instance, the working arrangement suggests that they are allocated 'temporary accommodation' in maternity wards because it is mentioned that if there are more maternity cases, then TOP clients, after undergoing the procedure, have to lie outside in the yard and wait to be examined and discharged. Furthermore, it is mentioned that if a TOP provider is busy attending to a TOP client and a maternity case arrives, then she has

to stop attending to the TOP client and give priority to the maternity case. This arrangement gives the impression that TOP clients are not treated the same as other health care users. This seems to suggest the logic of prioritizing “life” (in delivering newborns) over “death” (in aborting foetuses) and thus regarding abortion as less urgent and less important. This may have the undesired effect of discouraging clients from coming to these services because their privacy is not being maintained and are treated differently from other patients. As a result of this situation they may resort to backstreet abortions to avoid inferior treatment in health institutions. This also raises questions about the integration of abortion services into the health care system. Abortion services appear to be in a compromised position in comparison to other health care services.

Betty describes managers’ acceptance of abortion as conditional. This finding highlights the secrecy and contradictions around abortion. She says, for instance, that some managers require and appreciate the abortion service secretly when they are in a desperate situation. This suggests that because of the contradictory nature of abortion, some people may, in the public domain, distance themselves from abortion issues while in their private domain, may associate themselves with it. This may further serve to illustrate that the change in the legal status of abortion does not guarantee a change in peoples’ attitudes towards abortion.

The main source of emotional support for the participants in this study seems to be fellow TOP providers. Sharing of experiences with each other seems to serve as a platform for each of them to vent out their emotions. In the process of sharing experiences, meaning is

created collectively. They appear to have developed a common identity as service providers as they identify with each others' struggles. However, this important source of support and means of coping is probably perceived by participants at Kopano Health Centre as being denied. According to them, despite the availability of a number of nurses being trained in TOP, only one provider is allocated to the unit while others are allocated to other different units. Allocating one provider only also limits the number of clients who can be attended to and thus resulting in backlogs in abortion caseload. Clients that may be turned back because of the shortage of staff may resort to illegal abortion.

The theme of isolation and rejection is also illustrated in terms of the experiences of the clients. Most of the participants seem to be of the opinion that clients' decision to stop using contraceptives stem from the fear of being potentially rejected by their partners.

All the participants in the present study report positive attitudes from their family members and communities where they come from. This seems to be experienced and perceived by the participants as acceptance. Most of them report positive attitudes and acceptance from colleagues as well with the exception of Helen who complains about the negative attitudes of a few of her colleagues. This finding is not completely in line with the findings by Ndlhovu (1999) who highlighted that health professionals involved in TOP services face the challenge of being ostracized and victimized by their colleagues and communities in which they live.

These findings thus indicate some improvement in people's attitudes towards TOP providers. It has been just over a decade since the legalization of abortion, and this change in attitudes may be an indication that with time more people are gradually accepting women's right to choose to have an abortion and that nurses who choose to be involved have a right to do so. From a social constructionist point of view, this gradual change in the attitudes of people may be understood in the context of meaning being constantly created in the constantly changing and evolving nature of social interactions. For service providers, being accepted by colleagues, families, and communities plays an important role for their continued involvement in the service. Being faced with the challenges that they are faced with, social support serves as a buffer against psychological distress.

Another finding of this study is that most TOP providers blame family planning providers and clients for the increase in TOP requests. Family planning providers are blamed for not equipping clients with information about contraceptives to enable them to prevent unwanted pregnancies. Clients, on the other hand, are blamed for not taking responsibility in terms of regulating their fertility. This blaming could be understood as a way of letting out the frustration around the increased workload and perhaps as a way of dealing with the self-blame that they sometimes experience. In this way, the blame is directed outwards and it lessens the discomfort of self-blame.

According to the findings of the study, all the participants show a commitment to the service despite them experiencing feelings of being rejected, frustrated, and

overwhelmed. These participants do not seem to be stuck in a service that they would rather not be involved in. This finding is inconsistent with the Marek (2004) study which indicated that nurses in South Africa expressed dissatisfaction with their role in abortion. In general, the dissatisfaction that is expressed in the current study seems to be linked to conditions of work as opposed to resulting from conflicting values.

The participants in the current study appear to experience their involvement in the service as internally rewarding. However, despite this being a rewarding experience for them, all the participants, with the exception of Carol, were found to be of the opinion that there is a need for them to be financially rewarded for their involvement in a service which not every health provider wishes to be involved in. If they do receive this financial compensation, it will probably be viewed as a sign of acknowledgement and acceptance of the service. They also probably view it as a way of encouraging them to deal with the challenges of the service and to continue to be involved in the service.

This study also indicates that with the gradual acquisition of working experience, the participants tend to experience themselves as competent and confident. However, this opportunity to become experienced and competent in abortion work is sometimes compromised as demonstrated by the complaints raised by participants working at Kopano Health Centre where they are not always allocated to perform TOPs.

Even though there are commonalities in the experiences of these participants, differences are also evident. Dolly, for instance, is the only participant in whose story the theme of

ambivalence is particularly evident. This is not surprising, considering the fact that abortion is one phenomenon that has been shown to create moral and professional dilemmas. The TOP service at Kopano Health Centre where she is working is located in a maternity ward. Her dilemma could be understood in the context of her being caught in a situation where she is sometimes called to deliver babies and alternating that with the abortion of foetuses. On a broader scale, the dilemma could be attributed to her being in a profession which promotes the value of the sanctity of life while at the same time partaking in a procedure which is generally socially defined as an act of 'killing'. She therefore, seems to be caught between the social, professional, and legal constructions of abortion. She appears to deal with this discomfort by focusing on what she perceives to be the benefits of her involvement in the service, which is helping those in need of help and putting others' needs before hers.

Another theme that illustrates differences in how these participants construct reality, in this case, the reality around abortion, is the theme of fear. This theme characterizes Helen's story. Her fear could be interpreted as related to the religious construction of abortion. Based on her religious beliefs, she seems to feel that abortion is morally unacceptable. She seems to cope by asking for God's approval and understanding. Her perception of her involvement in abortion work as an act of saving other human kind may be her other coping strategy for dealing with the contradictions between the religious and legal aspects of abortion.

There are also differences in terms of the participants' experiences of rejection and acceptance. Carol, for instance, is the only participant who perceives management as supportive and accepting of the TOP service and its providers. She is a service provider at Tsohle Hospital. All the participants at both Lesedi Hospital and Kopano Health Centre perceive managers as being unsupportive. This, therefore, highlights differences at the level of health institutions. These variations in managers' support seem to suggest that issues of support are negotiated at institutional levels.

The findings of this study further suggest that being involved in TOP has become a personal responsibility or mission for the participants. Taking abortion work as a personal crusade appears to have been influenced by the participants' experiences of having witnessed women dying of complications of illegal abortion. The legalization of abortion seems to give them a sense of control over the situation as they probably felt helpless in the past when women were dying.

Participants such as Betty and Dolly appear to cope with the challenges in their work environments by using avoidance. Betty, for instance, stopped going to church to avoid feeling rejected. Dolly tends to physically and emotionally distance herself whenever she feels overwhelmed. The participants' tendency to focus on the positive aspects of their work may be an illustration that people tend to continue with behaviour which they experience as internally rewarding or for which they are externally rewarded. The experiences of these participants illustrate that in general, people employ different coping strategies when faced with situations that threaten their emotional stability.

6.3. Conclusions

Service providers' feelings of being rejected and isolated by managers of health institutions are found to be still predominant. This concern was raised in previous studies and this therefore suggests that not much has been done to address this problem. For a service, particularly a newly established one like TOP to function effectively, the support of management is critical. The Department of Health, in addition to initiating programs such as debriefing sessions, need to take a step further by ensuring that these initiatives are being implemented.

In some institutions, abortion services are located within the Obstetrics and Gynaecology departments. However, this integration seems to be only structural and not with the actual rendering of the services as demonstrated by other patients receiving priority over TOP clients and managers not checking up on TOP clients and providers as they do with other patients and nurses. For abortion services to run effectively, they need to be recognized and supported by those in management positions.

Even though the current findings indicate some improvement in peoples' attitudes towards abortion, abortion has also been shown to be still creating moral and professional dilemmas for some individuals.

There seems to be poor coordination between the functioning of TOP and family planning services; hence, the blaming that is evidenced in the participants' stories. These services seem to be currently operating in isolation.

6.4. Recommendations

TOP service providers are directly performing abortions and as highlighted by other previous studies; they need emotional/psychological and infrastructural support in order for this service to be rendered effectively. Hospital managers need to be encouraged to attend to the needs of the service providers. The Provincial Department of Health can facilitate this process by making follow up visits in order to monitor progress.

In order to deal with the issue of shortage of TOP trained staff, more nurses have to be recruited into the service. This will ease the service providers' frustrations and feelings of being overworked. In addition, mechanisms directed at retaining the current staff have to be put in place; for instance, paying the service providers 'scarce skills' allowance.

In order to address the problem of poor compliance with contraceptive use and to encourage post abortion family planning, the functioning of abortion and family planning services need to be integrated. There should, for instance, be direct referral between these services. If TOP service providers are to be expected to issue contraceptives, then more nurses need to be trained and allocated to the TOP service.

The findings of this study indicate that the unsatisfactory conditions in the provision of TOP services in the public health facilities are mainly related to the lack of infrastructure and equipments. Future studies could focus on comparing the provision of TOP services in public and private TOP facilities since the private facilities are generally well resourced.

6.5. Limitations of the study

Conducting of the interviews in the participants' language and then transcribing and translating into English is a limitation as some meaning might have been lost during the process. A further limitation is that some of the participants, despite having been assured of confidentiality, might have withheld their honest thoughts and beliefs related to their experiences in their work environment for fear that the information might jeopardize their relationships at work.

This study is based on social constructionism. In line with the views of this theoretical perspective, the understanding and interpretation of the interview data is context- bound. The findings of this study were influenced by the values of the participants and the researcher who together co-created the reality around abortion. This could be viewed as a limitation from the point of view of traditional positivist researchers who focus on objective reality and the generalization of findings.

REFERENCES

Allen, D.V.; Reichelt, P.A. & Shea, S. (1997). Two measures of nurses' attitudes toward abortion as modified by experience. *Medical Care*, 15(10), 849-857.

Althaus, F.A. (2000). Work in progress: The expansion of access to abortion services in South Africa following legalization. *International Family Planning Perspectives*, 26(2), 84-86.

Basu, A.M. (2003). **The sociocultural and political aspects of abortion: Global perspectives**. Westport: Praeger.

Becvar, D.S. & Becvar, R.J. (1996). **Family Therapy: A systemic integration**. (3rd Ed.). Boston: Allyn & Bacon.

Becvar, D.S. & Becvar, R.J. (2003). **Family Therapy: A systemic integration**. (5th Ed.). Boston: Allyn & Bacon.

Becvar, D.S. & Becvar, R.J. (2006). **Family Therapy: A systemic integration**. (6th Ed.). Boston: Allyn & Bacon.

Burke, J. (2000). **Educational research: Quantitative and qualitative research**. Boston: Allyn & Bacon.

Burr, V. (1995). **An introduction to social constructionism**. London: Routledge.

Cecchin, G. (1992). **Constructing therapeutic possibilities**. In McNamee, S. & Gergen, K.J. (Eds). *Therapy as social construction*. Pp (86-95). London: Sage Publication.

Cele, N. (2000). **Perceptions of women who visit the abortion clinics for termination of pregnancy during the transformation period in Kwa-Zulu Natal**. Unpublished Masters Thesis. University of Zululand: Natal.

Claire, M. (1995). **The abortion dilemma: Personal views on a public issue**. New York: Insight books.

Cottingham, J. & Myntti, C. (1999). Reproductive Health: Conceptual Mapping and Evidence. *Reproductive Health Matters*, 4, 84-109.

Creswell, J.W. (1998). **Qualitative inquiry and research design: Choosing among five traditions**. London: Sage Publishers, Inc.

Department of Health, Limpopo Province. 2008.

Department of Health, Republic of South Africa, 2008.

Dickerson, V. & Zimmerman, J. (1996). Myths, misconceptions and a word or two about politics. *Journal of Systemic Therapies*, 15(1), 79-87.

Dixon-Mueller, R. (1990). Abortion policy and women's health in developing countries. *International Journal of Health Services*, 20(2), 297-314.

Doan, R. E. (1997). Narrative therapy, Post modernism, Social Constructionism: Discussions and distinctions. *Transactional Analysis Journal*, 27(2), 129 – 131.

Ellen, M.; Mwaba, K.; Makoala, S. & Trueman, K. (2004). **A facility Assessment of Termination of Pregnancy services in Limpopo Province, South Africa**. Chapel Hill, NC, Ipas.

Engelbrecht, M.; Pelser, A.J.; Ngweni, C. & Van Rensburg H.C.J. (2000). The Choice on Termination of Pregnancy Act: Some empirical findings. *Curationis*, 23(2), 4-14.

Faure, S. & Loxton, H. (2003). Anxiety, depression and self-efficacy levels of women undergoing first trimester abortion. *South African Journal of Psychology*, 33(1), 28-38.

Francome, C. (1984). **Abortion freedom: A world-wide movement**. London: George Allen & Unwin.

Freedman, J. & Combs, G. (1996). **Narrative therapy: The social construction of preferred realities**. New York: Norton.

Gergen, K.J. (2000). **An invitation to social construction**. London: Sage Publications.

Githens, M. & Stetson, D. (1996). **Abortion politics: Public policy in cross-cultural perspective**. New York: Routledge.

Gmeiner, A. & van Wyk, S. (2000). The painful reality of abortion: the story of nurses directly involved with women who chose to terminate a pregnancy. *Curationis*, 70-78.

Gorman, M. J. (1982). **Abortion and the early church: Christian, Jewish and pagan attitudes in the Greco-Roman world**. Downers Grove, Illinois: InterVarsity Press.

Guttmacher, S.; Kapadia, F.; Naude, T. & De Pontho, H. (1998). Abortion reform in South Africa: A case study of the 1996 Choice on Termination of Pregnancy Act. *International Family Planning Perspectives*. 24(4), 191-194.

Gyekye, A.B. & Akinboade, O.A. (2003). A Profile of Poverty in the Limpopo Province of South Africa. *Eastern Africa Social Science Research Review*, 19(2), 89-109.

Haffajee, S. (1997). **Predictors of abortion attitudes and willingness to perform abortions amongst medical students.** Unpublished Masters Thesis. University of the Witwatersrand: Gauteng.

Haroz, A.E. (1997). South Africa's 1996 Choice on Termination of Pregnancy Act: Expanding choice and international human rights to Black South African women. *Vanderbilt Journal of Transitional Law*, 30(4), 863-904.

Harrison, A.; Montgomery, E.; Lurie, M. & Wilkinson, D. (2000). Barriers to implementing South Africa's Termination of Pregnancy Act in rural Kwa-Zulu Natal. *Health and Policy Planning*, 15(4), 424-431.

Henning, E. (2004). **Finding your way in qualitative research.** Pretoria: Van Schaik Publishers.

Hoffman, L. (1995). **Exchanging voices. A collaborative approach to Family Therapy.** London: Karnac Books.

Hord, C.H. & Xaba, M. (2001). Abortion law reform in South Africa. Report of a study tour, Johannesburg, May 13-19. *Ipas*, 5-31.

Jacobson, J.L. (1990). **Worldwatch Paper 97: The Global Politics of Abortion.** Washington,D.C: Worldwatch Institute.

Joffe, C. (1986). **The regulation of sexuality: Experiences of Family Planning Workers.** Philadelphia: Temple University Press.

Khathide, A. (2006). (In City Press, 10/09/2006).

Kvale, S. (1996). **An introduction to qualitative research interviewing.** Thousand Oaks, California: Sage.

Marek, M.J. (2004). The nurses' attitudes toward pregnancy termination in the labour and delivery setting. *Journal of Obstetric- Gynaecological and Neonatal*, 33(4), 472-479.

Marshall, C. & Rossman, G.B. (1995). **Designing qualitative research.** London: Sage.

Maykut, P.S. & Morehouse, R. (1994). **Beginning qualitative research: A philosophic and practical guide.** London: Falmer Press.

McKee, K. & Adams, E. (1994). Nurse midwives' attitudes toward abortion performance and related procedures. *Journal of Nurse-midwifery*, 39(5), 300-311.

Mdleleni-Bookholane, T. (2007). **Factors related to and the consequences of the termination of pregnancy at the Umtata General Hospital, Eastern Cape.** Unpublished Masters Thesis. Walter Sisulu University: Mthata

Ndlhovu, M.P. (1999). **Nurses' experiences of abortion: An exploratory study of nurses' experiences in assisting with Termination of Pregnancy in South Africa and Zambia.** Unpublished Masters Thesis. University of Western Cape: Cape Town.

Ngwen, C. (1998). The history and transformation of abortion law in South Africa. *Acta Academica*, 30(3), 30-68.

Okonofua, F. (2006). Abortion and maternal mortality in the developing world. *Journal of Obstetrics and Gynaecology*, 28(11), 974-979.

Orr, N. (1995). Abortion – a debate. *South African Medical Journal*, 85(3), 139-140.

Owen, I.R. (1992). Theory and practice: Applying social constructionism to psychotherapy. *Counselling Psychology Quarterly*, 5(4), 385 – 402.

Packer, A.A. (2002). **Using Human Rights to change Tradition: Traditional Practices Harmful to Women's Reproductive Health in Sub-Saharan Africa.** New York: Intersentia.

Papaikonomou, M. & Niewoudt, J. (2004). Exploring parents' stories of coping with their child's cancer: A qualitative study. *South African Journal of Psychology*, 34(2), 283 – 300.

Parry, A. (1997). Why we tell stories: The Narrative Construction of Reality. *Transactional Analysis Journal*, 27(2), 119 – 126.

Pauw, K. (2005). PROVIDE Project Background Paper. **The Provincial Decision – making Enabling Project. Background Paper 2005: A profile of the Limpopo Province: Demographics, poverty, inequality and unemployment**, 1(9), 1-24.

Peeters, H. (1996). **Psychology: The historical dimension**. Tilburg: Syntax Publishers.

Petchesky, R.P. (2003). **Global prescriptions: Gendering health and human rights**. London: Zed Books.

Pillai, V. & Wang, G. (1999). **Women's reproductive rights in developing countries**. Brookfield: Ashgate.

Polit, D. & Hungler, B. (1995). **Nursing research: Principles and methods**. Philadelphia PA: Lippincott.

Potgieter, C. & Andrews, G. (2004). South African nurses' accounts choosing to be Termination of Pregnancy providers. *Health-SA-Gesondheid*, 9(2), 20-30.

Rapmund, V.J. (2000). Women's stories of depression: A constructivist approach. *South African Journal of Psychology*, 30(2), 20 – 30.

Rapmund, V.J. (2005). **Qualitative research lecture notes**. University of South Africa: Pretoria.

Republic of South Africa. (1996). Choice on Termination of Pregnancy Act (No. 92 of 1996). ***Government Gazette***. Pretoria: Government Printer.

Republic of South Africa (1975). Abortion and Sterilization Act (No. 2 of 1975). ***Government Gazette***. Pretoria: Government Printer.

Republic of South Africa (1978). Nursing Act (No. 50 of 1978). ***Government Gazette***. Pretoria. Government Printer.

Rosen, J.E. & Conly, S.R. (1998). **Africa's Population Challenge: Accelerating Progress in Reproductive Health**. Washington, D.C: Population Action International.

Sarkin, J.J. (1995). **The effect of a constitution and Bill of Rights on abortion in South Africa: A comparative study**. Unpublished Doctoral Thesis. University of Western Cape: Cape Town.

Shelley, J.A. & Miller, A.B. (1991). **Values in conflict**. Downers Grove III: Intervarsity Press.

Statistics South Africa, 2008.

Suffla, S. (1997). Experiences of induced abortion among a group of South African women. *South African Journal of Psychology*, 27, 214-222.

Terre Blanche, M. & Durrheim, K. (Eds.). **Research in practice: Applied methods for the social sciences**. Cape Town: University of Cape Town.

Valle, R.S. & Halling, S.H. (1989). **Existential – Phenomenological perspectives in Psychology: Exploring the breadth of human experience**. New York: Plenum Press.

Van der Westhuizen, C. (2001). “Advancing the Roles of midlevel Providers in Menstrual and Elective Abortion Care”. A paper presented at Kwa-Maritane Lodge, South Africa. 2-5 December, 2001).

Van der Westhuizen, C. (2005). **Gender instruments in Africa: Critical perspectives, future strategies**. Midrand, South Africa: Institute for Global Dialogue.

Varkey, S.J. (2000). Abortion services in South Africa: available yet not accessible to all. *International Family Planning Perspectives*, 26(2), 87-88.

Varkey, S.J.; Fonn, S. & Ketlhapile, M. (2000). The role of advocacy in implementing the South African abortion law. *Reproductive Health Matters*, 8(16), 103 – 111.

Ventura, M.J. (1999). Where nurses stand on abortion. *RN*, 62(3), 44-47.

Walker, L. (1996). "My work is to help the woman who wants to have a child, not the woman who wants to have an abortion": Discourses of patriarchy and power among African nurses in South Africa. *African studies*, 55(2), 43-67.

Webb, C. (1985). Nurses' attitudes to Therapeutic Abortion. *Nursing Times*, 81(1), 44-47.

Widdows, H; Idiakez, E.A. & Cirion, A.E. (2006). **Women's Reproductive Rights**. New York: Palgrave Macmillan.

APPENDIX 1

CONSENT FORM

Dear Participant

I am conducting a study on women's reproductive health services in South Africa. The study specifically deals with the experiences of Termination of Pregnancy service providers.

I would appreciate it if you volunteer to be interviewed for the purpose of the research. The interview will last between 45 minutes and an hour and there might be a need for a follow-up interview.

Your participation in this study is entirely voluntary and you can refuse to participate or stop at any time without stating any reason.

All information obtained during the course of this study is strictly confidential. Data that may be reported in scientific journals and in the investigator's thesis will not include any personal information, which could identify you as a participant in this study.

Thank you for your cooperation.

Yours sincerely

.....

Moipone V. Lebesse

I hereby confirm that I have been informed by the investigator about the nature of this research project, as described above, and I am prepared to participate in the study.

Participant's Name

Participant's signature
